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This thesis presents an analysis of the Third Party Collection Program (TPC) for inpatient and outpatient care at Naval Hospital Oakland (NHO), its implementation and its comparison with a civilian counterpart. The implementation is in accordance with DoD Instruction 6010.15 and the comparison is conducted with the Community Hospital of Monterey Peninsula (CHCMP). This thesis briefly introduces the reader to the hospital TPC program, the concept, the law and the program implementation responsibilities. It gives a brief explanation of the DoD Inspector General TPC program inspection of August 1990, conducted at twenty five different military hospitals nationwide. Also, it provides historical data and health services information of NHO and CHCMP. Third party potential collections data are broken down by individuals services (Army, Air Force, and Navy) from 1988 to 1994. The author concludes that NHO has established an effective inpatient TPC program in according with DoD Instruction 6010.15 but that the billing and collection process is not as effective as CHCMP. The outpatient TPC program is still in its developing stage, and NHO is working hard to have an effective and efficient program.

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THIRD PARTY COLLECTION PROGRAM; CASE STUDY OF NAVAL HOSPITAL OAKLAND AND COMMUNITY HOSPITAL OF MONTEREY PENINSULA

by

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of the requirements for the degree of

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ABSTRACT

This thesis presents an analysis of the Third Party Collection Program (TPC) for inpatient and outpatient care at Naval Hospital Oakland (NHO), its implementation and its comparison with a civilian counterpart. The implementation is in accordance with DoD Instruction 6010.15 and the comparison is conducted with the Community Hospital of Monterey Peninsula (CHOMP). This thesis briefly introduces the reader to the hospital TPC program, the concept, the Law, and the program implementation responsibilities. It gives a brief explanation of the DoD Inspector General TPC program inspection of August 1990, conducted at twenty five different military hospitals nationwide. Also, it provides historical data and health services information of NHO and CHOMP. Third party potential collections data are broken down by individual services (Army, Air Force, and Navy) from 1988 to 1994. The author concludes that NHO has established an effective inpatient TPC program in according with DoD Instruction 6010.15 but that the billing and collection process is not as efficient and effective as CHOMP. The outpatient TPC program is still in its developing stage, and NHO is working hard to have an effective and efficient program.

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I. INTRODUCTION

While the enactment of the Third Party Collection (TPC) Program gives the Department of Defense (DoD) hospitals additional revenues and represents a major step forward to improve the quality of medical services and the enhancement of health care services to DoD beneficiaries, it also presents many challenges to the service hospitals charged with the monumental task of implementation. The Naval hospitals, as one of the larger and more diversified health care services, will be faced with many decisions as it takes steps to implement the TPC program.

The TPC program is designed to collect from third party payers. Enacted by United States Code, title 10, sec. 1095 as section 2001 of Public Law 99-272, The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), allows the Government to collect from health insurance plans for reasonable health care services costs incurred on behalf of military retirees and dependents. The statute allows the Government to collect from insurance, medical service, or health plans the reasonable costs of health care services incurred by the United States at a military facility to the extent that the insurer would pay if the services were provided by a civilian hospital. Health care services include

both inpatient and outpatient health care as well as the provision of ancillary services.

DoD Instruction 6010.15, "Coordination of Benefits," March 7, 1991, made the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) responsible for issuing policy, guidance, and providing oversight to ensure that the TPC program is resulting in maximum collection. It also made the Secretaries of the military departments responsible for ensuring that the TPC program policies and directions are implemented and fully executed. Finally, it made the Commander of a military Medical Treatment Facility (MTF) responsible for aggressively implementing an effective TPC program and providing adequate resources, leadership and support [Ref. 1].

Under the authority of United States Code, title 10, sec. 1095, all funds collected from a third party payer for the costs of health care services provided at a Uniformed Service facility would be credited to the appropriation supporting the operation and maintenance of that facility. In order to provide a strong incentive to assure a high priority on the TPC program at the facility level, all funds collected on or after October 1, 1989 through the TPC program, except for amounts used to finance collection activities, would be available to the local military hospital responsible for the collection and would be over and above the hospital's direct budget authority [Ref. 1].

A. THE RESEARCH QUESTION

This thesis will address the following two questions:

1. Has Naval Hospital Oakland implemented an effective TPC program according to DoD Instruction 6010.15?
2. How effective is the Naval Hospital Oakland TPC program when compared with a civilian hospital TPC program?

B. SCOPE OF THE THESIS

The purpose of this thesis is to identify and describe the TPC program of a selected Naval hospital, Naval Hospital Oakland (NHO) and a civilian counterpart, Community Hospital of Monterey Peninsula (CHOMP). These two hospitals (NHO in Oakland, California and CHOMP in Monterey, California) were selected for this study due to their geographical location and similar patient work load (ie. beds, admission, occupancy rate, etc.). Specific attention is given to the implementation of the program at the Naval hospital, its costs and limitations. This study also looks at the resource requirements to implement the TPC program and the steps taken to have maximum collection possible from the third party payer.

This thesis will not argue the strengths, weaknesses and perceived usefulness of financial statements and reports generated. It will not constitute an indepth review of

accounting principles. It will not include a comparison of NHO TPC program with other naval hospitals or other services TPC program.

C. METHODOLOGY

Different research methodologies were used: interviews, observation, statistical analysis of TPC program account data and literature review. Interviews were conducted with key personnel involved in the TPC program at NHO and CHOMP as well as observation of the TPC program by walking through each step of the process of admission, billing and collection. Literature review was conducted by examining DoD Instructions and Manuals, internal hospital guidelines and Standard Operating Procedures (SOP).

D. BENEFITS OF THE STUDY

The Department of Defense, Bureau of Medicine (BUMED), The Commanding Officer of Naval Hospital Oakland (NHO), and all other military services hospitals will benefit from this study. This will be accomplished by an indepth analysis of the Third Party Collection program at a well known Military Treatment Facility. NHO is one of the four naval teaching hospitals nationwide and the second on the west coast. It will also be accomplished by studying and comparing the Third Party Collection program (TPC) of NHO with the TPC of a civilian hospital. This study will provide hospital managers

with a comprehensive and usable management tool for future implementation of TPC programs and for reviewing their current program.

E. THESIS CHAPTER SUMMARY

The first chapter briefly introduces the reader to the hospital TPC program, the concept, the law, and the program implementation responsibilities.

In Chapter II the author provides an overview of the Bureau of Medicine (BUMED) Instruction 7000.7, explaining the purpose, policy and procedures. Also, the author gives a brief explanation of the objectives, findings, and the recommendations of the DoD Inspector General TPC inspection of August 1990, conducted at 25 military hospitals nationwide.

Chapter III provides background information as well as the history, the health care services provided and important facts of the Naval Hospital Oakland (NHO) and Community Hospital of the Monterey Peninsula (CHOMP).

Chapter IV focuses on the data collection process, how the data were obtained and the analysis of such data.

Chapter V presents the author's conclusions and makes some recommendations for further research.

II. INSTRUCTION AND INSPECTION

This chapter will provide an overview of the Bureau of Medicine (BUMED) Instruction 7000.7, explaining its purpose, policy and procedures. Also, this chapter will give a brief explanation of the objectives, findings, and recommendations of the DoD Inspector General TPC inspection of August 1990, conducted nationwide at twenty five military hospitals (Army, Air Force, and Navy).

A. BUREAU OF MEDICINE AND SURGERY TPC INSTRUCTION

The Bureau of Medicine and Surgery (BUMED) Instruction 7000.7 talks about the implementation of the TPC program as instructed by DoD. The following report gives a brief explanation of the BUMED Instruction [Ref. 2].

1. Purpose

To implement DoD Instruction 6015.5 [Ref. 1], by publishing procedures and assigning responsibilities for an aggressive TPC Program at all Naval MTFs.

2. Policy

a. All patients covered by applicable insurance plans should be identified and claims be processed to recover the greatest amount possible for the reasonable costs of medical treatment funded by BUMED claimancy from third party payers.

b. All funds collected from a third party payer for the costs of inpatient and outpatient hospital care provided at a uniformed service facility should be credited to the appropriation supporting the operation and maintenance of that MTF facility.

c. All reasonable costs will be determined by DoD and updated annually based on available cost and expense data. This rate determination may include a multiple rate system for inpatient care and a high cost/high volume for outpatient care.

d. All funds collected under the TPC Program, except for amounts used to finance collection and patient administration activities in direct support of insurance collections, should be used to enhance health care services.

e. A decision on whether to treat a beneficiary for hospital care should not be influenced by whether the beneficiary is covered by a third party payer.

f. All MTF commanding officers should ensure an aggressive program for maximum collections from third party payers to the fullest extent allowed by law.

3. Procedures

a. Establish an Effective TPC Program. This involves more than billing third party payers. Under the new Congressional guidelines, the TPC program now encompasses many different insurance policies and collection mechanisms. The

TPC program, therefore, now requires reviewing all aspects of accounts receivable management and necessitates the participation of many offices within the MTF including admissions, medical records, utilization review, ancillary departments, data processing, fiscal, and supply.

b. Health Insurance Verification. Verification should be made upon the occasion of each admission or visit to the MTF. Written certification should be obtained from all beneficiaries at the time of each admission and the initial outpatient visit (update annually). "Outpatient insurance will be verbally verified at each subsequent outpatient visit in the form of a question as to whether coverage status has changed or whether the insurance carrier has changed."

c. Billing Activities. MTFs will accurately prepare and submit claims to third party payers in a timely manner. The MTF should use the DD Form 2502 "Uniform Billing for Inpatient Hospital Costs", to prepare bills to third party payers for all outpatient and inpatient medical care and services rendered to dependents and retirees. Billings should be prepared and forwarded to the third party payer within 10 days following the dictation of the patient medical record but in no instance greater than 30 days following the day the patient is discharged. In situations involving long term hospitalization of beneficiaries, interim billings should be made from the MTF. Billings for outpatient care will be forwarded to the third party payer for payment within 5 days

of the patient visit. Third party collection authority has been expanded to include automobile liability, no fault insurance policies and those policies that fall under the National Recovery Act [Ref. 2].

B. DoD INSPECTOR GENERAL AUDIT REPORT

On August 30, 1990 the DoD Inspector General (IG) completed a report on a TPC audit conducted from October 1987 through November 1989 of selected military service hospitals nationwide. The following is a brief description about the objective of the audit, the Inspector General findings and their recommendations [Ref. 3].

1. Objectives

The overall audit objectives were to evaluate procedures prescribed by the Military Departments and practices followed by military hospitals to collect from private insurers for inpatient care provided to military dependents and retirees. Specific objectives were to determine whether:

a. DoD provided constructive guidance and support for the service's Surgeons General and the military hospitals to effectively implement and manage the TPC program.

b. Selected military hospitals had effectively implemented and adequately resourced the TPC program.

c. Selected military hospitals had effectively implemented procedures to identify those inpatients who had

insurance coverage and to document that all inpatients were questioned about their insurance coverage, to ensure that all claims were correctly prepared and submitted to the insurance companies, and to resolve all open claims and claims that were unpaid or partially unpaid.

d. Selected military hospitals had implemented effective systems to administer and manage the TPC program.

e. Reporting requirements adequately measured the effectiveness of the TPC program.

The IG performed work at 25 military hospitals, and at each hospital they reviewed claims and amounts collected for inpatients who were discharged during FY 1988 and the first quarter of FY 1989. The IG also reviewed the TPC program policies, procedures, guidance, and the systems implemented to administer and manage the TPC program. According to reports generated by the Defense Medical Systems Support Center there were 489,338 military dependent and retiree inpatients discharged from military hospitals nationwide during FY 1988. The IG reviewed 4,313 claims totaling $11.4 million, or approximately 35 percent of the $32.7 million claimed for FY 1988. The IG reviewed 920 claims totaling $2.6 million, for the first quarter of FY 1989. In addition, the IG determined if the military hospitals had obtained a signed insurance statement from each patient by randomly sampling the files of a least 130 inpatients (dependents and retirees only) who were

discharged during FY 1988 and the first quarter of FY 1989. The IG team also evaluated internal controls for weaknesses applicable to the audit objectives.

2. Findings

The following are the findings of the IG inspection team:

a. Military hospitals were not collecting from the primary health insurance plans for inpatient hospital care costs incurred on behalf of insured military dependents and retirees.

b. Military hospitals had not established adequate procedures to identify inpatients with health insurance coverage and document that inpatients had been questioned about insurance coverage, and to resolve open claims and claims that were unpaid or partially unpaid.

c. Neither the ASD(HA) nor the Surgeons General for the Military Departments were adequately reviewing quarterly reports submitted by military hospitals to assure that the TPC program was fully implemented.

d. The Surgeons General and military hospitals did not have sufficient DoD support and guidance to effectively implement and manage the TPC program.

e. ASD(HA) had not identified or adequately developed the basic systems needed to implement and manage the TPC program. ASD(HA) had not corrected the deficiencies in the

current automated system for preparing insurance claims. This system would not permit users to reprint claims as needed and add or delete information after the claim forms were printed.

f. The Surgeons General had not fully installed the system for preparing the insurance claims or given hospital personnel enough training to make the system operational. Military hospitals had developed and implemented several ineffective and disorderly systems to manage the TPC program.

g. The Surgeons General and military hospitals' command were unclear about the rights and the obligations of the third party payers and the health care beneficiaries.

h. Military hospitals did not have a management information system to effectively manage the TPC program, thus making management and review of the TPC program difficult and time consuming by not providing accurate, reliable, and easily accessible information and the necessary audit trails or internal controls.

i. Seven of the twenty five military hospitals visited were collecting from Medicare supplemental insurance policies for the cost of inpatient care for insured military retirees and dependents. Military hospitals and private insurance companies were unclear about obligations for payment on Medicare supplemental insurance policies.

The IG audit showed that for claims paid by insurance companies, all military hospitals collected about 80 percent of the amount claimed for FY 1988, and about 81 percent of the amount claimed for the first quarter of FY 1989 (see Appendixes J and K). The projected TPC program collections for each military hospital showed that for FY 1988, military hospitals should have collected a total of about $66.4 million. Appendixes L, M, N give a comprehensive amount breakdown from all military hospitals.

The following Tables (I and II) show the potential additional collections from the military departments that the IG projected for FY 1988 as well as the projected collections from all military hospitals from FY 1988 to FY 1994:

TABLE I
TPC POTENTIAL COLLECTIONS FOR FY 1988

MILITARY DEPARTMENT	AMOUNTS COLLECTED	PROJECTED COLLECTIONS	REVENUE FOREGONE
ARMY	$ 7,808,448	$31,476,130	$23,667,682
NAVY	1,511,276	11,054,365	9,543,089
AIR FORCE	6,912,272	23,913,544	17,001,272
Totals	$16,231,996	$66,444,039	$50,212,043

TABLE II
TPC PROJECTED COLLECTIONS FROM MILITARY HOSPITALS

FY	CURRENT	PROJECTED	DIFFERENCE
1988	$ 16,231,996	$ 66,444,039	$ 50,212,043
1989	17,205,916	70,430,681	53,224,765
1990	18,238,271	74,656,522	56,418,251
1991	19,332,567	79,135,914	59,803,347
1992	20,492,521	83,884,068	63,391,547
1993	21,722,072	88,917,112	67,195,040
1994	23,025,397	94,252,139	71,226,742
Totals	$ 136,248,740	$ 547,730,475	$ 421,471,735

Table II shows that for every $1.00 collected $3.00 more could have been collected (obtained by dividing the total of the "DIFFERENCE" column by the total of the "CURRENT" column = $3.09).

3. Recommendations

a. The IG recommended that the Surgeons General direct the commanding officer at military hospitals to fully implement and adequately resource the TPC program. This could be done by the military hospitals by establishing procedures for:

- Identifying inpatients who have insurance coverage and documenting that they have been questioned about insurance coverage.
- Correctly preparing and submitting claims to insurance companies.
- Resolving open claims and those claims that were unpaid or partially unpaid for different reasons.

b. The IG recommended that the ASD(HA) and the Surgeons General for all the services (Army, Air Force and Navy) review quarterly reports submitted by the military hospitals to ensure that the TPC program is implemented and fully executed, and take corrective actions at those hospitals that have not fully implemented the TPC program.

c. The IG recommended that the ASD(HA):

- Develop and issue a DoD instruction providing specific policies, procedures, and responsibilities for implementing the TPC program.
- Develop and issue a DoD regulation clarifying the rights and the obligations of the third party payers and health care beneficiaries.
- Develop and make available the systems needed to implement and manage the TPC program (i.e. a MIS using the Automated Quality of Care Evaluation Support System (AQCESS)).
- Correct the deficiencies in the AQCESS for preparing insurance claims, thus permitting the users to add or delete information and reprint claims as needed.

d. The IG recommended that military department Surgeons General fully install at each military hospital the AQCESS and any other systems that could help to manage the TPC program as well as giving hospital personnel sufficient training to operate the systems.

e. The IG recommended that if legislation that would authorize military hospitals to collect from Medicare supplemental insurance is enacted, that the ASD(HA) issue guidance requiring military hospitals to collect from such insurance policies.

Only 1 (Eisenhower Army Medical Center) of the 25 military hospitals the IG visited had effectively implemented the TPC program. The IG projected that unless the TPC program is effectively implemented, the military hospitals will fail to collect approximately $318.0 million from insurance companies for FY 1990 through 1994.

In the next chapter (Chapter III) the author gives background and historical information on both hospitals; Naval Hospital Oakland (NHO) and the Community Hospital of Monterey Peninsula (CHOMP).

III. HOSPITALS BACKGROUND

This chapter gives background information as well as the history, the health care services provided and important facts of the Naval Hospital Oakland (NHO) and Community Hospital of the Monterey Peninsula (CHOMP).

A. COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA

The Community Hospital of the Monterey Peninsula (CHOMP) is a private, not-for-profit and acute-care hospital. It is fully licensed and accredited and has 172 private rooms. It is served by a medical staff of 199 physicians (77 medical specialist, 76 surgical specialists, and 46 other specialists), 529 nursing personnel, 345 clinical personnel, and 519 support personnel (this represents full/part time personnel). There are about 500 active and student volunteers [Ref. 3].

CHOMP began in 1927 as a hospital primarily for research into metabolic disorders and treatment of patients who suffer from them. It was later converted into a general community hospital in 1934 after experiencing financial difficulties. In 1955, trustees decided that growth of the community dictated construction of a new hospital. With financial support from the community, a 100-room hospital was built in

1962 on the present site at the top of Carmel Hill. The $2.5 million facility was the first community hospital in the county to offer all private rooms, each with a window opening to the sylvan landscape of the Monterey Peninsula. The hospital was expanded to 172 rooms in 1971. In 1988, CHOMP completed construction of an Outpatient Surgery Center to house the ever-increasing numbers of outpatient surgical procedures expected to account for at least half of all surgeries by the end of the next decade. The Outpatient Surgery Center is equipped with the latest technology and equipment to facilitate same-day surgeries, and is designed for maximum patient comfort and convenience.

Services offered by CHOMP are as follows:

A. **Pharmacy:** operates 24 hours a day, 365 days a year to fill prescription needs of inpatients and outpatients; staffed by 12 pharmacists, 12 technicians and a manager; fills about 150 take-home prescriptions daily.

B. **Surgery:** handles about 600 cases per month in six operating room suites; staffed by 45 specialists; provides 24-hour-a-day coverage.

C. **Short Stay Unit:** saves patients time and money for routine, outpatient surgeries; prepares about 160 morning admission patients for surgery each month; handles about 250 outpatient surgeries each month; staffed by 15 nurses.

D. **Cardiopulmonary:** diagnoses and treats respiratory and heart diseases; staffed by 24 technicians; provides

diagnosis studies and cardiac monitoring; administers wellness programs.

E. Physical Therapy: cares for patients of all ages disabled by illness or accident or born with a handicap; provides specific therapies.

F. Occupational Therapy: operates two clinics, one for those recovering from surgery and learning to cope with physical ailments and the other for patients with mental and emotional problems; assists patients in returning to home and work.

G. Emergency: provides 24-hour-a-day services; handles about 2,500 patients each month; staffed by a team of emergency physician specialists and about 40 specially trained nurses.

H. Radiology: operates Diagnostic Center, Radiation Therapy, and X-Ray Department; employs CT whole body scanner, nuclear medicine camera, ultrasound equipment, and a mobile magnetic resonance imager in addition to x-rays.

I. Dietary: plans, prepares and serves about 1,000 tasty and nutritious meals each day; meets special patient dietary needs.

J. Laboratory/Blood Center: open 24-hours-a-day, seven days a week to perform more than 400 different tests on inpatients and outpatients; staffed by about 70 full-time and part-time employees; prepares and tests 80 to 90 percent of blood used at this hospital.

K. Oncology: provides 14 beds for active treatment of cancer patients; staffed by about 25 nurses specially trained to give extra care.

L. Labor and Delivery/Berthing Center: handles about 125 deliveries each month; staffed by about 20 nurses; provides childbirth classes; offers Birthing Center for childbirth in a home-like setting; makes home visits to new mothers and babies.

M. Intensive Care Unit: provides 10 beds for intensive/coronary care patients, especially heart attack patients, those with acute respiratory problems, and acute post-operative patients.

1. Facts

- Treats about 11,500 inpatients and 120,000 outpatients each year.
- There are about 7,000 surgeries performed each year, on both inpatient and outpatient basis.
- Approximately 1,700 babies are born each year.
- The Blood Center collects about 5,000 units of blood each year and meets approximately 90 percent of the need for blood locally.
- A special education network is operated for the benefit of patients.
- The Dietary Department serves more than 500,000 meals each year, to patients, visitors and staff.
- In an average year, the hospital handles about 35,000 cases in its Emergency Department.

B. NAVAL HOSPITAL OAKLAND

Naval Hospital Oakland (NHO) is located in a peaceful and beautiful country setting in the midst of one of the largest and most culturally diverse metropolitan areas in the United States. Nestled in the foothills of Oakland, conveniently located near Freeway 580, the medical treatment facility employs about 2,200 people, including 550 civilians. The Hospital is staffed with dedicated health professionals who have available for their use a great amount of the most modern equipment in the medical field.

1. History

NHO was commissioned on July 1, 1942, with six ward buildings and 204 beds. In 1945, at the climax of the Pacific war, the hospital was caring for more than 6,000 patients with a military and civilian staff of approximately 3,000. Contractors brought the total number of buildings on the 220-acre compound to 135, including a chapel, Navy Exchange, library, and a few sets of living quarters for staff.

With demobilization, both the activity and the population declined, only to rise again during the Korean conflict when the daily patient census averaged 2,500. This figure fell to a peacetime level of about 600, but with the influx of Vietnam casualties beginning in 1965, the tempo of life increased again, both in patient care requirements and in morale building activities. On December 7, 1965 ground was

broken for a new permanent hospital, and in mid 1968 the new facility was completed and received its first patients. Building 500 is today a nine story, attractive, modern, and well equipped hospital facility, fire-resistant, with a frame of reinforced concrete and walls of precast concrete panels.

Most of the temporary buildings have been demolished to make way for the multi-storied hospital, but some have been retained to house such facilities as the San Francisco Medical Command, Navy Exchange store, Special Services, Library, Security, Fire Department, maintenance and transportation shops, and other supporting operations.

On January 1, 1973, NHO was consolidated into the Naval Regional Medical Center, Oakland. The regional concept was aimed at providing medical services at the branch clinics which were easily accessible to beneficiaries, yet allowing centralized and consolidated health care support resources to ensure a high degree of efficiency and effectiveness.

The present 9-story medical complex was dedicated on June 29, 1968, in time to render medical support to United States combat forces in Southeast Asia. For their outstanding service the hospital was awarded a Meritorious Unit Commendation from the Secretary of the Navy in 1973.

As one of the Navy's four teaching hospitals, NHO is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In fact, in 1990, the hospital received its latest three-year accreditation with a

score of over 90 out of possible 100. The hospital offers 12 graduate medical education residencies, as well as fellowships and internships. Additionally, there are enlisted technician schools in Preventive Medicine, Operating Room Technicians, and Basic Radiology, as well as in-service training programs in urology and other services.

As a high-profile member of the Oakland community, NHO is valued for its participation in outreach activities. The heroic involvement of its personnel in the rescue efforts during the historic October 1989 Loma Prieta earthquake is a case in point; its unique teaching partnership with Skyline High School is another. Appreciation for the hospital personnel's contributions is well documented in the local media, first with references to USNS Mercy's (T AH-19) homecoming on April 23, 1991. At the onset of Operation Desert Shield, in August 1990, NHO deployed about 541 medical and support personnel to the hospital ship, as well as 127 corpsmen, eight physicians and one nurse to Fleet Marine Force units in Saudi Arabia. Several tenant activities are based at NHO, including the Naval School of Health Sciences San Diego, San Francisco Medical Command and the Navy Drug Screening Laboratory [Ref. 5].

2. Services provided

The following medical services are provided at NHO for active duty military personnel, their dependents and retirees:

- Adolescent Clinic
- Audiology and Speech
- Allergy Clinic
- Cardiology
- Dental (including Oral Surgery)
- Dermatology
- Diabetic
- Dialysis
- Ear/Nose/Throat
- Endocrinology
- Emergency Room
- Family Planning
- Gastroenterology
- General Surgery
- Gynecology
- Hand Therapy Clinic
- Hematology/Oncology
- Immunizations
- Internal Medicine
- Infertility
- Laboratory
- Mental Health
- Nephrology
- Neurology and Neurosurgery
- Nuclear Medicine
- Nutrition

- Obstetrics
- Ophthalmology and Optometry
- Orthopaedics and Podiatry
- Pediatrics
- Pharmacy
- Physical/Occupational Therapy
- Plastic Surgery
- Primary Care Clinic
- Orthotics Laboratory
- Pulmonary Medicine and Function Laboratory
- Radiation Therapy
- Radiology (X-Ray)
- Rheumatology
- Social Services
- Thoracic Surgery
- Tumor Registry
- Urology
- Vascular Surgery

3. Mission

The mission of NHO is to [Ref. 5]:

a. Provide, as directed, health care services in support of the operation of the Navy and Marine Corps shore activities and units of the operating forces.

b. Provide a comprehensive range of outpatient and inpatient health care services to active duty Navy and Marine

Corps personnel and active duty members of other federal uniformed services.

c. Ensure that the command is maintained in a proper state of material and personnel readiness to fulfill wartime and contingency mission plans.

d. Conduct appropriate education programs for assigned military personnel to ensure that both military and health care standards of conduct and performance are achieved and maintained.

e. Ensure that all assigned military personnel are both aware of and properly trained for the performance of their assigned contingency duties.

f. Maintain requisite quality health care standards so as to ensure successful accreditation and recognition by appropriate governmental and civilian agencies and commissions, to include the JCAHCO.

g. Subject to availability of space and resources, provide the maximum range and amount of comprehensive health care services possible for other authorized persons as prescribed by Title 10, U.S. Code, and other applicable directives.

h. Cooperate with military and civilian authorities in matters pertaining to public health, local disasters and other emergencies.

i. Participate as an integral element of the Navy and Tri-Service Regional Health Care System.

j. Conduct graduate and postgraduate education programs for naval medical students and medical departments officers.

4. Facts

- Teaching Hospital Capacity:

Normal	225 Beds
Expandable	560 Beds (Disaster/Contingency)
	625 Beds (Wartime)

- 80 structures providing 930,000 square feet
- Operational helo pad
- 81 Family Housing Units
- FY 1992 Budget and Manpower:

Medical Activities	$56,059,000
Maintenance of Real Property	4,149,000
Base Operations	15,139,000
Total	$75,347,000

Military Payroll	$80,931,000
Civilian Payroll	23,946,000
Total	$104,877,000

Military Personnel	1,968
Civilian Personnel	680
Total	2,648

IV. DATA COLLECTION AND ANALYSIS

This chapter focuses on the data collection process obtained for this case study and the analysis of such data.

A. DATA COLLECTION

The data for this case study spans the time period from FY 1988 to June of FY 1992, and were collected from a variety of sources. The earliest possible completed information obtained about patients from CHOMP is calendar year 1990. Due to the infancy of the outpatient TPC program the data obtained from BUMED and NHO is limited.

The primary sources of data for this case are listed below, and will be analyzed subsequently in detail:

1. Implementation of the TPC program at NHO.
2. NHO inpatient and outpatient third party collections from FY 1988 to June of FY 1992.
3. Observation and personal interviews of the TPC program at NHO.
4. Interviews of key personnel staff at CHOMP on the admission, billing and collection process from third party payers.

1. NHO TPC Program Implementation

This section describe the procedures followed by NHO administrative staff to implement their version of an

effective TPC program [Ref. 6 and 7]. The purpose was to clearly identify those active duty dependents and retirees, who have insurance through a private health plan. The implementation is broken down in two interrelated sections: Admission and Billing procedures.

a. **Admission Procedures**

The admission office personnel interview all pre-admission and regular admissions for inpatients, regarding insurance, medical service, or health care plan coverage.

When,a patient has private insurance coverage, line 11 will be marked "YES" on the Electronic Health Insurance Form, DD Form 2569 (Appendix A) and Section II will be completed. If the patient does not have private insurance, line 11 will be marked as "NO" and the patient will sign block 27.

The admissions Supervisor drops off the completed insurance form to the Coordinator of Benefits (COB), on the 5th floor (Patient Administration Department) of the main hospital building, for processing. This process is done two to three times daily. COB obtains the following information from the Health Insurance Agency:

- eligibility of inpatient for health insurance coverage plan;
- what benefits are under the plan;
- who the review organization is and their phone number;
- whether review organization has given prior authorization;

- whether admission requires concurrent review;
- billing address of insurance company;
- name and phone number of point of contact who provided information.

Everyday an admission clerk pulls the Emergency Room (ER) Log report from AQCESS to identify those patients admitted from the ER to the ward, so that an insurance form can be delivered to the patient to complete (Appendix F).

For patients who claim coverage, the COB review the DD Form 2569 for completeness and accuracy. If additional information is needed or the information provided needs clarification, the COB contact the patient either at the hospital or at home.

Everyday, the newly received forms are called to Billing and Collection Division (Fiscal Department) for entering into the computerized system. This provides the required information for the Pre-Certification Roster from AQCESS, using procedures outlined in Appendix C.

On a daily basis, the insurance forms (DD Form 2569) marked "Yes" are compared against the daily Discharged Log (Appendix D). If a patient has not been discharged, the insurance forms are placed into pending colored file.

Once a patient is discharged, completed charts are dropped off by the respective wards to the Chart Control room. Chart Control pre-analyzes charts for missing or incomplete information. A discrepancy sheet is completed (Appendix E).

The COB is responsible for resolving discrepancies listed on the pre-analysis sheet (Appendix E). These discrepancies are: missing Blank Face Sheet from physician, missing Narrative Summary or Operative Report from the attending physician, and missing Tissue Reports from the Laboratory.

When the Face Sheet and the Narrative Summary have been obtained, the chart is turned over to Lead Coder. The lead Coder codes charts and returns them to COB when completed. Any charts unable to be coded due to missing Tissue or Operative report are placed in the Insurance Holding box.

The COB obtain the coded charts having a copy of the following information (Appendixes G,H,I,O,P, and Q):

SF 6300/5	Admission/Discharge Cover Sheet
SF 539	Abbreviated Medical Record (if the patient has been admitted for less than 72 hours)
SF 516	Operative Report
SF 502	Narrative Summary (admitted for more than 72 hours)
Computer	Completed Attestation Sheet
SF 508	Doctor's Orders

Upon patient's discharge, a completed insurance packet and the original DD Form 2569 are sent to Billing and Collection (Fiscal Department). A copy of this form is placed in the patient's chart.

b. Billing Procedures

When the completed insurance packet and original DD Form 2569 are received, information is recorded on the billing log and the next numbers are used as the billing number. The bill form UB82 is typed (Appendix T).

The first three copies of UB82 and two copies of all information except for the patient Data Sheet are sent to the insurance company.

A copy of the bill is attached to the explanation of policies and the medicare explanation. The bill is mailed to the insurance company.

If no response is received from the insurance company after 15 days of the date that the bill was mailed, a call is placed to the insurance company. After the first call, another call is placed to the insurance company every 15 to 20 days to follow up on any action that is taking place until receipt of either a payment or denial.

A record of conversation with the insurance company is attached to the file copy UB82 every time the insurance is contacted.

When the check is received from the insurance company the UB82 is pulled and the date, the amount of payment and the amount of denial is recorded on the Billing Log. Then the payment and is posted and the record on the AQCESS system is updated.

The received check is sent to the collection office, and a copy of it is attached to the UB82 on file.

When a denial is received a determination of the reason for the denial is made. If the reason is valid the UB82 is filed with a copy of the denial letter and the file closed. If the reason of denial is not valid, the insurance company is contacted.

2. NHO Insurance Benefits From FY 1988 to FY 1992

Table III (inpatient) compares the inpatient data for the last four fiscal years as well as the current one and it gives a comprehensive breakdown of the third party payer collection. On Table IV (outpatient) the outpatient third party payer data is limited to FY92 due to DoD not approving such collection data from these patients until early FY92. The source of this data is from different reports generated by Billing and Collection in the Fiscal Department. On the following page, the line numbers explain the reasons given on both tables for uncollected dollar amounts of amount billed :

1. Open claims (This requires additional follow-up action by the MTF for resolution)

LINES (2-6). THIRD PARTY REDUCED/DENIED PAYMENT FOR INVALID REASONS

2. MTF not a participating hospital

3. Plan excludes military hospitals or beneficiaries

4. Patient had no obligation to pay

5. Insured paid patient directly

6. Other (need explanation)

LINES (7-12). CLOSED CLAIMS; THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS

7. Amount of coverage (i.e plan pays less than 100%)

8. Patient not covered, care provided not covered, or policy expired

9. Medicare, Champus, Income supplemental plans

10. Health Maintenance Organization (i.e. non-emergency out-of-plan care not covered)

11. MTF did not comply with utilization review procedures (i.e. pre-admission screening, concurrent review, second surgery opinions, etc.)

12. Other (need explanation)

TABLE III
COMPARATIVE YEARS TREND TPC PROGRAM (INPATIENT)

	FY 88	FY 90	FY 90	FY 91	FY 92
A	8,853	12,450	12,140	10,636	-
B	-	-	8,714	7,713	6,416
C	248	317	315	612	735
D	$433,176	$ 724,204	$ 861,026	2,162,544	2,998,634
E	$274,644	$ 309,522	$ 6,422	$ 294,838	$ 455,669
F					
1	N	$ 13,628	$ 0	$ 267,033	1,207,936
2	O T	93,423	0	0	0
3		127,869	0	25,902	693
4	A	26,182	0	603	0
5	V	22,230	0	36,180	0
6	A	131,350	0	0	0
7	I L	0	516,424	373,698	57,204
8	A	0	98,264	23,321	107,892
9	B	0	233,000	1,087,178	1,152,255
10	L	0	6,916	53,064	15,422
11	E	0	0	724	1,563
12		0	0	0	0
	Totals	$ 414,682	$ 854,604	1,867,703	2,542,965

Table III legend:

A ---> the number of admissions including: military, military dependents and retirees.

B ---> the number of non-active duty patients.

C ---> the number of bills sent to third party payer or the number of UB-82 forms submitted.

D ---> the dollar amount billed to third party payer.

E ---> the dollar amount collected from third party payer.

F ---> allowances broken down by category (open claims, invalid denials, and invalid billed charges).

"-" ---> information not readily available

TABLE IV
NHO TPC PROGRAM OUTPATIENT BENEFITS FY 1992

No. of UB-82 Forms Submitted	705
Amount Billed	$ 54,285
Amount Collected	$ 1,930
Allowances (by category)	
(1)	0
(2)	0
(3)	0
(4)	0
(5)	0
(6)	0
(7)	232
(8)	154
(9)	11,346
(10)	0
(11)	0
(12)	0
Total	$ 11,732
Amount Outstanding	$ 40,623

3. NHO TPC Program Observation and Interview

On July 23 and 24 of 1992 interviews were conducted with key staff personnel directly involved with the TPC program (Appendix R). Physical observation of the TPC process was also conducted, keying on the following departmental staff personnel: Admission, Billing, and Collection. What follows

are the results of such interviews [Ref. 8] and observation of the TPC program (see Appendix I for the questions asked):

BEFORE AND DURING ADMISSION

1. Patients are first questioned about health insurance coverage, upon their admission.

2. The patient insurance plan is verified.

3. This verification is done after the patient has been admitted.

4. Patient Administration personnel are responsible for doing the insurance verification.

5. The patient insurance verification is conducted over the phone.

6. During the verification process insurance approval for the patient care is obtained.

7. There are three to four personnel involved in the verification process.

8. Personnel are permanently assigned to this position.

9. This question is not applicable.

10. Assigned personnel are required to undergo on the job training.

11. The training is one day long.

12. The training is given inhouse.

13. Refresher training is given all year around.

14. The cost of training per employee is not available.

15. The Patient Administration Department Head is responsible for the training.

16. The major problem encountered with insurance company thus delaying the payments, is that, the authorization for the Government to collect from insurance company is not on

the Code of Federal Regulation (CFR) which is the insurance company guidelines.

17. The time and cost spent on correcting errors is unknown.

ONCE THE PATIENT IS ADMITTED

18. Patient billing information is collected upon patient discharged.

19. The Admission/Discharge Cover Sheet (SF 6300/5) is used when the patient is admitted and discharged. Patient Administration Department is responsible for filling up this form.

20. Patient Administration Department is responsible for the coding of patient information.

21. The patient coding is done utilizing computers.

22. The patient billing information is sent to the Billing Department, upon patient discharged.

23. The patient billing information is not updated on a daily basis.

24-30. Are not applicable.

BILLING AND COLLECTION

31. The insurance company is billed after the patient has been discharged.

32. The bill is forwarded to the insurance company thirty days or more after the patient is discharged.

33. The average account receivables (collections) turnover for health insurance billing are seventy five days.

34. NHO does not have payment terms.

35. The percentage of claims that are unpaid or partially unpaid are as follow:

	# Claims Collected		# Claims Submitted		Percentage
FY 1992	351	/	735	=	47.75
FY 1991	239	/	612	=	39.05
FY 1990	2	/	315	=	0.006

36. Sixty five percent of the claims require follow up billing.

37. Billing follow ups are conducted by mail and phone.

38. The service of an outside collection agency is not utilized.

39-43. Are not applicable.

44. The percentage of account receivables (amount billed) that are uncollectible for various reasons are as follow:

	Invalid Charges	Amount Billed		Percentage
FY 1992	$1,334,335	$2,998,634	=	44.50
FY 1991	$1,537,985	$2,162,544	=	86.37
FY 1990	$ 854,604	$ 861,026	=	99.25

45. They have not considered contracting out the billing and collection (i.e. Clearing House); they claimed that is economically unfeasible.

46. There are instances that the amount billed has been adjusted downward by the insurance company due to NHO not getting pre-authorization.

47. They have heard about Electronic Claim.

48. They will be considered using in the hospitals setting since they think to believe that Electronic Claim is quicker and cost effective.

49. The current computer software used for inpatient billing and collection is AQCESS.

50. The AQCESS system was bought by DOD in 1989, NHO has no knowledge of the purchase price and maintenance cost.

4. CHOMP Interview on: Admission, Billing and Collection

The following information was obtained during an interview conducted with CHOMP Vice President for Financial Services [Ref. 9]:

BEFORE AND DURING ADMISSION

1. Patients are first questioned about health insurance coverage during admission registration or when are referred by a staff physician.

2. The patient health insurance plan is verified with the insurance company.

3. This verification is done upon patient admission.

4. Administration/Patient relation personnel are responsible for patient verification.

5. Patient insurance verification is conducted over the phone.

6. During verification process insurance approval for patient care is obtained.

7. There are two to three personnel involved in the patient verification process.

8. Personnel are permanently assigned to this position.

9. This question is not applicable.

10. Assigned personnel are required to undergo on the job training.

11. The training is six months long.

12. The training is given inhouse.

13. Refresher training is given all year around.

14. The cost of training per employee is about $200.

15. Individual Department Heads are responsible for the training of their personnel.

16. The major problem encountered with insurance company delaying the payments, is that, the insurance company always wants additional patient information when the bill exceeds $10,000.

17. The time and cost spent on correcting errors is unknown.

ONCE THE PATIENT IS ADMITTED

18. Patient billing information is collected at midnight during patient census.

19. Request slips are used when requesting service (i.e. laboratory, x-ray). The request is filled up by the nursing station.

20. Each department is responsible for the coding of patient information.

21. The patient coding is done utilizing computers, except for laboratory requests which are done manually.

22. The patient billing information is sent to the Billing Department on a daily basis.

23. The patient billing information is updated on a daily basis.

24. Management Information System (MIS) Department is responsible for keeping the patient information updated.

25. The MIS personnel responsible for keeping the information current are assigned as their primary duty. There are about twenty personnel working in the MIS Department.

26. The only skills necessary to update the patient information is to have clerical skills or data entry experience.

27. There is ongoing training for the personnel assigned to this duty. Training is conducted inhouse as well as outside.

28. The training is coordinated by the MIS Department.

29. The annual MIS departmental training cost to keep their personnel up-to speed is about $8,000.

30. The per patient cost of information collection is unknown.

BILLING AND COLLECTION

31. The insurance company is billed upon patient discharge. If the patient is hospitalized for long term care, then interim bills are mailed to insurance company.

32. The bill is forwarded to the insurance company six days after the patient is discharged.

33. The average account receivables (collections) turnover for health insurance billing are seventy five days.

34. CHOMP does not have payment terms for the insurance company.

35. The percentage of claims that are unpaid or partially unpaid were not available.

36. Most of the claims required follow up billing.

37. Billing follow ups are conducted by mail and phone.

38. The service of an outside collection agency is utilized but only for direct patient billing.

39. The criteria used for selecting the current collection Agency was the agency ability to collect from the patients without having to apply too much pressure, thus maintaining a good hospital-patient relationship.

40. The cost of utilizing the collection agency is about thirty five (35) cents per each dollar collected.

41. They changed collection agency only once, 15 years ago.

42. The account receivables (collection) are referred to the collection agency after being outstanding for over 90 days.

43. The percentage of patient billings referred to the collection agency is about five percent.

44. Four percent of the account receivables (collection) are uncollectible for different reasons.

45. They have not considered contracting out the billing and collection (i.e. Clearing House), they claimed that it is easier to maintain inhouse.

46. There are instances that the amount billed has been adjusted downward by the insurance company up to 100 percent in some instances (i.e. MEDICAL) for not getting pre-authorization.

47. They have heard about Electronic Claim. The approximate cost is about one dollar per claim plus 25 cents to 50 cents per attachment fees.

48. They are considering the use of Electronic Claim, since they believe that collections will be sent and received faster than presently are. Medicaid and Medicare collections are currently billed using Electronic Claim through Blue Cross and Blue Shields. Presently, they are looking for an Electronic Claim system that could be comparable with all insurance company.

49. The current computer software used for inpatient and outpatient billing and collection is called SMS.

50. The approximate cost for this system is about four million, includes hardware and software. This system required annual maintenance. Maintenance cost was not available.

B. DATA ANALYSIS

The data and information from NHO and CHOMP were collected and analyzed. The following are the findings:

1. Naval Hospital Oakland

a. NHO is collecting from the primary health insurance plans for inpatient hospital care costs incurred on behalf of insured military dependents and retirees (Table III).

b. NHO has established adequate internal control procedures to identify inpatients with health care insurance coverage and to document that the inpatients were questioned about their health insurance coverage (Appendix A) and also, to insure that claims are correctly submitted to the insurance company and to resolve open claims and claims that were unpaid or partially unpaid (Table III).

c. NHO does not yet have sufficient DoD support and guidance to effectively implement and manage the TPC program.

d. NHO has an automated system for preparing inpatient insurance claims (AQCESS). The AQCESS system is very limited (i.e. unable to send partial billing to insurance company for long term care patients).

e. NHO is collecting from Medicare supplemental policies but this amount is very limited.

f. NHO is submitting the quarterly reports to BUMED as required by DoD Instruction 6015.15 [Ref. 1].

g. NHO is not confused about the rights and obligations of third party payers and health care beneficiaries.

h. NHO Commanding Officer is ultimately responsible for the TPC program but the implementation task has been delegated to the Deputy Controller.

In addition to the findings mentioned above, the NHO findings are broken down into the following sections:

Admission

The Admission office is having tremendous difficulties performing their task. The office is located on the ground floor of the main building, which is very accessible to the inpatient but the room is too small and uncomfortable to work in, not a good atmosphere for patient admission. Patient Administration Department is located on the fifth floor of the main building, and could not provide a prompt response on patients and/or admission staff personnel questions on admission procedures or policies.

Admission personnel question the patients about insurance coverage. They make a copy of the patient insurance identification and attach it to the computer print out, DD Form 2569 (Appendix A). If the AQCESS System is down, a hand written form is used (Appendix S).

All relevant information are collected and annotated through the AQCESS System on DD Form 2569 (Appendix A). Patients appear to be cooperating with admission personnel by answering relevant patient information questions as well as insurance coverage. Patients are signing the above mentioned form upon conclusion of the interview.

There is no system in place that could provide the admission clerks and/or supervisor immediate feedback on data entry errors committed by the admission clerks while completing the patient admission form (Appendix A) (i.e.

annotating on the form that the patient has no insurance coverage when he/she does).

Billing and Collection

There is no automated system to print and update outpatient billing. All billings are done and tracked manually.

Billing and collection personnel are very knowledgeable on the TPC program. They attempt to be professional and courteous when confronted with difficult questions.

As illustrated on Table III, inpatient collections have been steadily increasing for the past five years sending a positive sign that the current TPC system is on track and improving. Outpatient collections as illustrated on Table IV are on track.

Insurance companies are billed based on a flat per diem rate per patient ($701 for inpatient, $77 for outpatient) and updated at the start of a new fiscal year. CHOMP and other civilian institutions do detailed billings.

AQCESS Computer Software

The Automated Quality of Care Evaluation Support System (AQCESS), which is a standard military MFT system, was designed to collect and report clinical, administrative and management information necessary for the inpatient portion of

the DoD medical quality assurance program. The basic modules of AQCESS are; Admission and Disposition, Clinical Records, Quality Assurance and Ad Hoc reporting.

AQCESS has the capability to switch to a reduced input admission screen more suited for mass casualty use, than the normal admission/registration input screen. This capability speeds patient admission by reducing the data items required for admission.

AQCESS provides support for data collection, insurer billing, claim processing, account tracking, collection and reporting of inpatient TPC program [Ref. 10].

AQCESS allows insurance charges to be calculated automatically for patients with valid insurance data on file. The insurance billing function provides a detailed history of transactions per account and claim, of the charges, payments, balance, uncollectible amount, transfers, write-offs and refunds.

AQCESS permits billing of primary and secondary insurance policies, in addition to posting multiple payments for any claim. AQCESS provides notification to the TPC Coordinator of any insurance accounts requiring additional data in order to continue insurance processing. Some of reports generated by AQCESS are:

- Separate Insurance Active Accounts Receivable
- Log of Opened Insurance Claims

- Report of Insurance Payments
- Reconciliation reports for TPC summary data reports
- TPC Aging of Insurance Accounts Receivable
- TPC Report of Program Results, spanning three fiscal years
- TPC Monthly Medical Services Activities for Insurance
- Separate Line for Insurance in the Collection Agent Accountability

More detailed information about the AQCESS can be found on the AQCESS Insurance Billing Handbook for Patient Administration Personnel [Ref. 10].

SENTIENT System

SENTIENT is a new software computer system much similar to AQCESS which is going to be utilized exclusively for inputting, updating, billing, and reporting outpatient information (Appendix B).

Some of the most important reports generated by SENTIENT are:

- Accounts Receivable Report
- Aging Summary
- Claims Audit Report
- Insurance Payment Report
- Daily Deposit Slip
- Unprinted Claims Report
- Visit Charges by Patient

- Invoices
- Statements
- Claim Forms

The overall cost of implementing this system is approximately $15,000. SENTIENT should be fully implemented and operational by FY 1993.

2. Community Hospital of The Monterey Peninsula

Admission

The patient admission office is located on the first floor of the main building. It provide a hospitable and pleasant atmosphere, making the patient feel relaxed and comfortable. It makes me feel like I am checking in to a hotel rather than a hospital.

All question regarding insurance coverage are asked by the admitting physician prior to the patient being admitted, thus getting any problems, approvals, or misunderstanding resolved prior to admission. All relevant patient information are collected and entered in the custom-made computer system.

This automated and advance computer system provides the admission clerks, supervisors and management with an immediate feedback on data entry errors committed during admission.

Admitting clerks are well paid ($25,000 average) and they undergo initial on the job training lasting approximately

six months before being assigned on their own. The clerks are professional, courteous and helpful to everyone.

Billing and Collection

The inpatient and outpatient information collection process is fully automated. Everyday the patient billing information is updated by the Management Information System personnel, thus providing an up-to-date bill. The cost of implementing this effective computerized system is about four million dollars, including computer software and hardware.

The bill is forwarded to the insurance company within six days of patient discharge, thus maintaining their account receivables at or below the national average (75 to 80 days). The bills are fully itemized. If the patient stay is long term, interim bills are sent to the insurance company. This provides a much needed cash inflow prior to patient discharge.

Some of the reports generated by CHOMP automated computer system are:

- Aging Accounts Receivable
- Active Accounts Receivable by Insurance Company
- Daily Accounts Receivable
- Daily Cash Balance
- Daily Deposit
- Invoices

V. CONCLUSIONS

The topic of this thesis has been the Third Party Collection Program (TPC) implemented in accordance with DoD Instruction 6010.15 [Ref. 1]. This chapter answers the two thesis research questions:

1. Has Naval Hospital Oakland implemented an effective TPC program according with DoD Instruction 6010.15?

2. How effective is Naval Hospital Oakland TPC program when compared with a civilian counterpart?

A. ANSWERS TO RESEARCH QUESTIONS

The following information recaps the author's findings of NHO and CHOMP TPC program and answers the primary research question:

NHO is collecting from the primary health insurance plans for inpatient and outpatient hospital care costs incurred on behalf of insured military dependents and retirees. But, it lacks proper DoD support and guidance to effectively implement and manage an effective TPC program.

NHO's admissions office is having difficulties accomplishing its mission due to inadequate room spaces and lack of formal training of personnel. CHOMP's admission office is well staffed, strategically located, comfortable to work in, and its personnel are fully trained.

NHO's admission office is located on the first floor while the Patient Administration Department is on the fifth floor. This distance creates confusion and misunderstanding between personnel due to lack of communication and patient problem solving mechanisms. CHOMP's admission office and central office are adjacent to each other on the first floor; admission clerks, supervisor and management alike have established good rapport and communication flow is very easy.

For those inpatients who indicate that they do not have health insurance coverage, the admission office personnel attachs the original signed form in the patient medical record. For those that indicate that they do have insurance coverage, a signed form copy is attached to their record and the original is sent to the billing office. All financial accounting for billings, collections, and the disposition of the third party collections are done in accordance with DoD Accounting Manual [Ref. 11].

NHO establish and maintain accounting records as required which can report: (a) what action was taken on each claim; (b) the amount collected; (c) the amount identified or resolved as invalid billings; (d) the delinquent amount; (e) the final account disposition; and (f) how the amount collected was spent.

NHO is accurately preparing and submitting claims to the third party payers. NHO is using DD Form 2502, "Uniform Billing for Inpatient Hospital Care" (UB82), to prepare bills

to third party payers for medical care and services rendered to dependents and retirees.

NHO is using a per diem rate equal to the inpatient and outpatient full reimbursement rate, subdividing the inpatient bill into hospital, physician and ancillary charges. Military beneficiaries are not required to pay NHO any deductible or copayment amounts imposed by the third party payer.

NHO is doing appropriate follow ups for each claim in which the third party response is unsatisfactory. This follow up is well documented and conducted by telephone contacts and letters.

NHO patients admitted through the emergency room are not questioned about health care insurance coverage. Patients are questioned on coverage a few days later and are often not questioned or interviewed at all. CHOMP interviews patients admitted through the emergency room on the spot unless the patient is critically injured.

NHO does not have adequate instructions and guidelines to properly implement and collect from the outpatient population. Current computer software (AQCESS) is solely used for inpatients and is not capable of doing outpatients without a major program overhaul. A system called SENTIENT (Appendix B) for outpatient billing and collection is currently being considered and should be implemented on FY 1993. CHOMP

inpatient and outpatient billing and collection computer software are integrated and user friendly.

AQCESS addresses most of the medical status boards in Hospital Administration. It generates standard admission and disposition forms. AQCESS is not the perfect system but provides a method for ensuring that the standards of health care are met.

CHOMP and NHO TPC programs are similar in nature, both striving to collect from a common source "Third Party Payers." However, there is considerable difference on how they gather patient information and the amount billed to the third party payer. NHO patient billing information is not updated on the AQCESS system on a daily basis; it is only done when the patient is discharged from the hospital. The amount billed to the insurance company or third party payer is a flat rate and this rate is updated yearly, for example:

	RATE	DAYS	TOTAL
HOSPITAL CHARGES	$ 428.00	6	$ 2568.00
ANCILLARY SERVICES	238.00	6	1428.00
PROFESSIONAL FEE	35.00	6	210.00
TOTAL CHARGES			$ 4206.00

CHOMP updates its patient billing information daily; at any given day it can actually print a patient bill summary without interrupting the routine process. CHOMP is billing the insurance company on a flat per diem rate while NHO is

not. CHOMP itemizes all services provided to the patient. CHOMP is a non profit organization and, therefore, their job is to cover their cost incurred for services provided from each patient. On the other hand, NHO is without doubt operating at a loss and inefficiently from a cost perspective, since it is not recovering the full patient care costs for services provided.

Based on the information provided and analyzed above and in previous chapters, it appear that NHO has established an effective inpatient TPC program in according with DoD Instruction 6010.15. However, the billing and collection process is not as effective and efficient as similar systems at CHOMP. NHO is presently striving to establish a more effective and efficient outpatient TPC program.

B. AREAS FOR FURTHER STUDY

Some productive areas for additional research on this topic are recommended:

1. Evaluate and compare the Army, Air Force and Navy TPC program. Which program is the most effective and efficient?

2. Examine and evaluate different DoD hospitals TPC program. Which program is the most appropriate and cost effective to be implemented DoD wide?

Answering the above questions could provide, the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) and the Commander of a military Medical Treatment Facility with a reliable management tool to effectively implement and manage a comprehensive TPC program.

APPENDIX A

THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION
Form Approved OMB No. 0701-0001 Expires Mar 31, 1994

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095 and 32 CFR.
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for inpatient care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility.
ROUTINE USERS: The information on this form will be released only to your insurance company.
DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

SECTION I - PATIENT INFORMATION

1.Name WASHINGTON,SAM 2.SSN 3.DOB 23 JUN 1931
4.Register # 0166603 5.Marital Status M 6.Relation to Insured
7.Address 2725 CANYON CREEK DR 8.Telephone No: Home (209)473-0261
City/State STOCKTON CA Zip 95207 Office
9.Admission Date 23 JUL 1992 Hour 1322 10.Accident Date Hour
11.Do you have Health Insurance? Yes No X
12.If yes, is this a supplement to: CHAMPUS MEDICARE/MEDICAID

SECTION II - INSURANCE CARRIER INFORMATION

13.Name of Insured 14.SSN
15.Policy No:
a.Individual b.Group
16.Effective Date 17.Renewal Date
18.Is this the Primary Policy for Insurance Purposes? Yes No X
19.Individual Insurance Company Name
20.Insurance Co Address 21.Telephone No
City/State Zip Extension
22.Insured Employer Name
23.Employer Address 24.Telephone No
City/State Zip Extension
25.Name of Group Insurance Plan 26.Group Plan No

SECTION III - CERTIFICATIONS

27. Patient: I certify that the above information is true and accurate to the best of my knowledge. I hereby authorize and request that the proceeds of any and all benefits which may be due me under the attached claim(s) be paid directly to the facility of the uniformed service or other authorized representative of the United States for hospitalization and professional services provided me and/or my dependents.

(Signature of patient) (Date Signed)

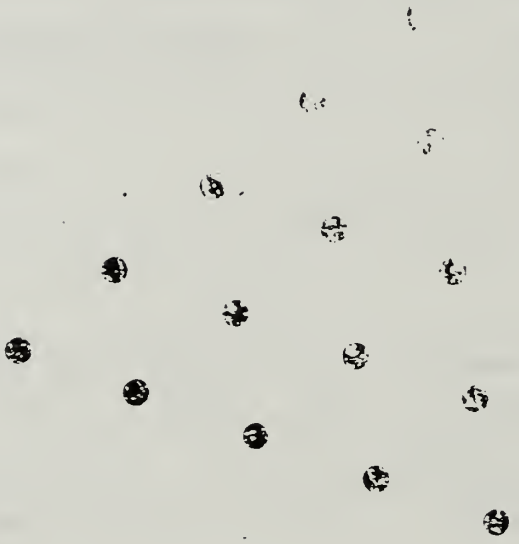
28. Third Party Liability Clerk: This admission has been identified as a Third Party Liability Case under PL 87-693. Yes ___ No ___

(Signature of TPL Clerk) (Date Signed)

DD Form 2569, FEB 91
ELECTRONIC FORM EXCEPTION APPROVED BY WHS/DIOR, FEBRUARY 91

APPENDIX B

SENTIENT
SYSTEMS



ACCLAIM™

MANAGEMENT REPORTS

Accounts Receivable Report

By Insurance Carrier

Purpose

To assess claims to a given carrier with a breakout by patient or subscriber

To serve as a reference to check billing accuracy

Features

Overview of outstanding insurance carrier accounts

Lists insurance company contact and phone number for followup

Variations

May be compiled by provider, place of service, billing category, insurance carrier, oldest balance, or several combinations of these categories

ACCOUNTS RECEIVABLE REPORT

John Harrison, M.D.

MEDICARE

CONTACT NAME: JOHN BARTON
CONTACT PHONE: 717-497-2749

RESPONSIBLE PARTY CHART#	BILL TYPE	NEW	CURRENT	30 DAYS	60 DAYS	90 DAYS	120+ DAYS	
JESSICA GOLDEN	MDC/REG	0.00	0.00	46.00	175.46	0.00	0.00	2
POL#: 755073218 (NO)								
	PATIENT:		CHARGE DATE(S):					
	JESSICA GOLDEN		11/18/91	6.00	Last RP Payment: 10/18/91			367.
			11/04/91	40.00	Last IC Payment: 10/04/91			40.
			10/30/91	169.46				
			10/18/91	6.00				
KATHY GOYNE	MDC/REG	0.00	0.00	135.00	0.00	0.00	0.00	1
POL#: 196716760 (NO)								
	PATIENT:		CHARGE DATE(S):					
	KATHY GOYNE		11/19/91	135.00	Last RP Payment: 11/08/91			105.
					Last IC Payment: 11/18/91			88.
TREVOR GOYNE	PP/PC	0.00	0.00	0.00	0.00	0.00	25.00C	2
POL#: 626984520 (NO)								
	PATIENT:		CHARGE DATE(S):					
	TREVOR GOYNE		12/28/87	25.00C				
JAMES GUNTHER	MDC/REG	0.00	0.00	122.00	0.00	0.00	0.00	12
POL#: 675214567 (NO)								
	PATIENT:		CHARGE DATE(S):					
	JAMES GUNTHER		11/19/91	122.00	Last RP Payment: 11/05/91			16.0
					Last IC Payment: 10/31/91			16.6
BRYAN HARRIS	MDC/REG	430.50	0.00	162.00	0.00	0.00	0.00	59
POL#: 281331862 (NO)								
	PATIENT:		CHARGE DATE(S):					
	BRYAN HARRIS		01/13/92	430.50	Last RP Payment: 11/08/91			16.0
			11/08/91	162.00	Last IC Payment: 10/16/91			69.3
PAULA HARRIS	MDC/REG	0.00	0.00	0.00	24.00C	0.00	0.00	2
POL#: 424383708 (NO)								
	PATIENT:		CHARGE DATE(S):					
	PAULA HARRIS		10/30/91	16.00	Last RP Payment: 09/27/91			51.3
			10/28/91	40.00C	Last IC Payment: 10/04/91			27.7
MARCIA HART	MDC/REG	0.00	0.00	40.00	0.00	0.00	0.00	4
POL#: 933003075 (NO)								
	PATIENT:		CHARGE DATE(S):					
	MARCIA HART		11/08/91	40.00	Last RP Payment: 03/05/91			50.00
					Last IC Payment: 05/14/90			25.13

ACCOUNTS RECEIVABLE REPORT

John Harrison, M.D.

MEDICARE

NTACT NAME: JOHN BARTON
NTACT PHONE: 717-497-2749

ONSIBLE PARTY	CHART#	BILL TYPE	NEW	CURRENT	30 DAYS	60 DAYS	90 DAYS	120+ DAYS	TOTAL
K ALLISON	(96272372)	MDC/REG	0.00	12.40	0.00	0.00	0.00	50.00	62.40
NETH WAYNE AMOS		MDC/REG	0.00	0.00	0.00	96.00	0.00	258.98	354.98
NT BAIN JR.		MDC/REG	0.00	0.00	0.00	56.00	32.50	0.00	88.50
THIA BORGFELDT	(7802122)	MDC/REG	0.00	50.00	98.00	0.00	0.00	40.00	188.00
UDE BOURGAULT		MDC/REG	0.00	0.00	137.25	0.00	7.83	0.00	145.08
TA BOWLES		MDC/REG	0.00	0.00	0.00	0.00	0.00	287.89	287.89
YTON BURKE		MDC/REG	0.00	0.00	178.00	40.00	0.00	0.00	218.00
NIS M BURKE		MDC/REG	0.00	0.00	40.00	0.00	40.00	17.00	97.00
SICA BURKE	(400638651)	MDC/REG	0.00	33.71	0.00	56.00	0.00	0.00	89.71
LIAM E CARSTENSEN		MDC/REG	0.00	0.00	0.00	0.00	77.00	528.84	605.84
Y CHEN		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56.00
K COATES		MDC/REG	0.00	0.00	0.00	223.55	0.00	0.00	223.55
ANNE CORDERMAN		MDC/REG	0.00	0.00	235.06	0.00	0.00	0.00	235.06
LLOYD DAWSON		MDC/REG	0.00	0.00	16.00	0.00	0.00	184.60	200.60
LY DUKE		MDC/REG	0.00	0.00	0.00	0.00	0.00	178.77	178.77
CY DUVALL		MDC/REG	0.00	0.00	56.00	40.00	0.00	0.00	96.00
AN EVERSOLE		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56.00
DRA GALLAGHER	(8061856)	MDC/REG	0.00	7.00	0.00	40.00	0.00	291.00	338.00
N GERCMETTA		MDC/REG	0.00	0.00	93.00	0.00	0.00	218.97	311.97
SICA GOLDEN		MDC/REG	0.00	0.00	46.00	175.46	0.00	0.00	221.46
HY GOYNE		MDC/REG	0.00	0.00	135.00	0.00	0.00	0.00	135.00
ES GUNTHER		MDC/REG	0.00	0.00	122.00	0.00	0.00	0.00	122.00
AN HARRIS		MDC/REG	430.50	0.00	162.00	0.00	0.00	0.00	592.50
DA HELLIER	(6047453)	MDC/REG	0.00	0.00	0.00	56.00	0.00	0.00	56.00
IE HELLIER		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56.00
TER HILLIARD		MDC/REG	0.00	0.00	83.00	22.00	6.00	75.19	186.19
HOOGENDOORN		MDC/REG	0.00	0.00	0.00	0.00	90.00	120.00	210.00
THA HOOGENDOORN		MDC/REG	0.00	0.00	56.00	0.00	40.00	448.50	544.50
CE INGRISANO	(224626394)	MDC/REG	0.00	0.00	77.00	0.00	0.00	0.00	77.00
HARD JORDAN		MDC/REG	0.00	0.00	93.00	0.00	0.00	0.00	93.00
BARA KENEIPP	(80733694)	MDC/REG	0.00	0.00	16.00	0.00	40.00	290.50	346.50
E KERNS		MDC/REG	0.00	0.00	115.50	0.00	0.00	0.00	115.50
IE KIRBY		MDC/REG	0.00	0.00	0.00	56.00	0.00	0.00	56.00
ES A. LANGFORD		MDC/REG	0.00	0.00	0.00	85.00	0.00	160.30	245.30
EN LAUGHERY		MDC/REG	0.00	0.00	0.00	92.00	0.00	0.00	92.00
ES LEECH	(36213750)	MDC/REG	0.00	0.00	0.00	56.00	0.00	0.00	56.00
AN LILAOCNWALA		MDC/REG	0.00	0.00	0.00	0.00	0.00	93.55	93.55
RA LIVINGSTON		MDC/REG	0.00	0.00	0.00	0.00	36.00	27.80	63.80
PH MARCH	(312259)	MDC/REG	0.00	0.00	0.00	56.00	40.00	496.66	592.66
HLEEN MCQUAIL		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56.00
SON L. MEADE		MDC/REG	0.00	0.00	16.00	0.00	0.00	353.31	369.31
N MILLER		MDC/REG	0.00	0.00	112.62	0.00	0.00	0.00	112.62

ACCOUNTS RECEIVABLE REPORT

John Harrison, M.D.

MEDICARE

CONTACT NAME: JOHN BARTON
CONTACT PHONE: 717-497-2749

RESPONSIBLE PARTY	CHART#	BILL TYPE	NEW	CURRENT	30 DAYS	60 DAYS	90 DAYS	120+ DAYS	T
GARY MOOSE		MDC/REG	0.00	0.00	0.00	0.00	0.00	279.51	279
SAMUEL NEWLAND	(805214785)	MDC/REG	0.00	0.00	117.00	0.00	0.00	58.50	175
JAMES NORTON		MDC/REG	0.00	0.00	90.00	66.00	34.00	0.00	190
SCOTT OAKES		MDC/REG	0.00	0.00	0.00	53.20	0.00	0.00	53
KRISTIN ORTON		MDC/REG	0.00	0.00	56.00	0.00	0.00	554.87	610
ELIZABETH PACK		MDC/REG	0.00	0.00	0.00	0.00	0.00	77.00	77
JANICE PARRISH		MDC/REG	0.00	0.00	40.00	50.00	0.00	0.00	90
MAIORCA PEETZ	(13334403)	MDC/REG	0.00	0.00	0.00	16.00	0.00	166.01	182
HAROLD PIERCE		MDC/REG	0.00	0.00	135.00	0.00	0.00	0.00	135
SAMUEL PIPAN		MDC/REG	0.00	0.00	40.00	40.00	0.00	0.00	80
TINA QUIGLEY		MDC/REG	70.00	0.00	135.00	0.00	0.00	0.00	205
GUY RICE		MDC/REG	0.00	0.00	699.00	0.00	0.00	0.00	699
DIANA RIPPLE-COMP		MDC/REG	0.00	0.00	122.00	0.00	0.00	0.00	122
BARBARA SAUNDERS		MDC/REG	0.00	0.00	223.55	0.00	0.00	0.00	223
GLADDEN SKELLY		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56
IRMA SKELLY		MDC/REG	0.00	0.00	0.00	0.00	0.00	179.62	179
KENNETH WAYNE STONE		MDC/REG	0.00	0.00	0.00	397.87	0.00	0.00	397
KARYN SWENHOLT		MDC/REG	0.00	0.00	76.00	40.00	0.00	0.00	116
JUDY TEMPLER		MDC/REG	0.00	0.00	0.00	71.20	146.25	0.00	217
JIM TERWILLIGER AUTO		MDC/REG	0.00	0.00	16.00	0.00	0.00	350.40	366
OLGA THOMPSON		MDC/REG	0.00	0.00	16.00	80.00	0.00	57.80	153
BIRGIT VAUGHAN		MDC/REG	0.00	0.00	0.00	0.00	77.00	0.00	77
NANCY VAUGHAN		MDC/REG	77.00	0.00	0.00	106.00	114.60	0.00	297
CURTIS WASHINGTON		MDC/REG	0.00	0.00	56.00	0.00	0.00	0.00	56
FAITH WEBER		MDC/REG	0.00	0.00	0.00	56.00	40.00	0.00	96
IRENE WELCH		MDC/REG	0.00	0.00	0.00	56.00	50.00	0.00	106
PEGGY WELCH		MDC/REG	0.00	0.00	167.55	0.00	0.00	0.00	167
JEANNETTE K. WORSHAM		MDC/REG	0.00	0.00	40.00	40.00	0.00	0.00	80
HUNTLEY YOEST		MDC/REG	0.00	0.00	172.73	0.00	0.00	0.00	172
TOTAL:			577.50	103.11	4,369.26	2,222.28	871.18	5,845.57	13,988
			(4%)	(1%)	(31%)	(16%)	(6%)	(42%)	(100

TOTAL RESPONSIBLE PARTIES: 71

Aging Summary

❖

Purpose

Additional tool to the accounts receivable report in the collection process

Review tool to determine key accounts needing collection emphasis

❖

Features

Provides easy access to detailed patient followup information

Sorts accounts by oldest balance

❖

Formats

May be compiled in detail or in summary

❖

AGING SUMMARY

John Harrison, M.D.

FOR BALANCE DATES 11/10/91 - 11/30/91

BALANCE DATE	BILL TYPE	PATIENT	CHART#	LAST PAID	LAST VISIT	BALA
11/12/91	PRIVA	MICHAEL EVANS		09/11/91	11/12/91	90
11/12/91	PRIVA	BRUCE KAHOONEI			11/19/91	580
11/12/91	PRIVA	HELEN LISA		07/10/89	11/15/91	152
11/12/91	PRIVA	LUCY MURRAY		09/09/91	11/12/91	482
11/12/91	PRIVA	PATRICIA PERRY		09/13/91	11/20/91	297
11/13/91	PRIVA	SHERYL BRENNAN			11/13/91	337
11/13/91	PRIVA	JORENE KHATTAR		01/29/91	11/15/91	139
11/13/91	PRIVA	ANDREA LINVILLE		09/18/91	11/13/91	121
11/13/91	PRIVA	PAUL WELLS	650798600	09/05/91	11/13/91	267
11/14/91	PRIVA	DENNY DEERING		11/14/91	11/14/91	261
11/14/91	PRIVA	WAYNE LORITSCH		10/07/91	11/14/91	6
11/14/91	PRIVA	BRUCE STANTON	208067	07/01/91	11/19/91	542
11/14/91	PRIVA	EUGENIA WALLBANK		07/12/91	11/14/91	123
11/14/91	PRIVA	FRANK WIESER		08/05/91	11/14/91	6
11/14/91	PRIVA	JOHN YOEST		08/26/91	11/14/91	61
11/15/91	PRIVA	JOHN T. KINSER	9089500	10/22/91	11/20/91	144
11/15/91	PRIVA	ANNE LIVINGSTON		09/26/91	11/15/91	40
11/15/91	PRIVA	JENNIFER RIPPLE-COMP		07/17/91	11/15/91	114
11/15/91	PRIVA	KAREN SHIRLEY		11/12/91	11/15/91	139
11/15/91	PRIVA	NANCY STRIBBLING		10/15/91	11/15/91	158
11/18/91	PRIVA	RUTH CLARK	19198	09/17/91	11/18/91	72
11/18/91	PRIVA	TRAVIS DAUNT			11/18/91	142
11/18/91	PRIVA	ELIZABETH FIORMONTI	349145251	11/18/91	11/18/91	25
11/19/91	PRIVA	CLAYTON BOURGAULT		11/07/91	11/19/91	334
11/19/91	PRIVA	RONALD W. CHILTON		11/04/91	11/19/91	27
11/19/91	PRIVA	MARJORIE HEINBAUGH		09/06/91	11/19/91	327
11/20/91	PRIVA	NICOLE BRADLEY		11/12/91	11/20/91	16
11/20/91	PRIVA	JANE B. FERRIN		11/15/91	11/20/91	61
11/20/91	PRIVA	KATHLEEN LUSKEY		11/20/91	11/20/91	61
11/20/91	PRIVA	VIRGINIA SPRAGUE	9163965	10/28/91	11/20/91	16
11/20/91	PRIVA	MARCIA TOMEI		11/18/91	11/20/91	35
11/20/91	PRIVA	COURTNEY WILBER	9422830	11/20/91	11/20/91	125
11/20/91	PRIVA	JANICE WILBER		11/04/91	11/20/91	16
				TOTAL:		$5,573

Claims Audit Report

❖

Purpose

To track outstanding claims

To create insurance tracers on unpaid claims

❖

Features

Creates a batch of claims for resubmittal

Lists claim date, amount, status, and any payments

Provides summary by carrier

❖

Variations

May be sorted by carrier type, carrier, billing status, and payment status

May include primary claims, secondary claims, or both

❖

Formats

May be compiled for any user-specified time period

❖

CLAIMS AUDIT REPORT - SUMMARY

John Harrison, M.D.

CLAIM DATES: BEGIN - 01/11/92
CARRIER TYPE: 3
CLAIM TYPE: PRIMARY/SECONDARY
BILLING STATUS: 1,2,3
PAYMENT STATUS: 1 (UNPAID)

CARRIER: MDC (MEDICARE)

CLAIM DATE	PATIENT	CHART#	VISIT DATE	AMOUNT	STATUS	PYM
02/16/88	BONNIE SCHLEEPER		02/16/88	20.00	UNPRINTED	NON
03/11/88	BONNIE SCHLEEPER		03/11/88	20.00	UNPRINTED	NON
03/31/88	BONNIE SCHLEEPER		03/31/88	19.50	UNPRINTED*	NON
04/14/88	BONNIE SCHLEEPER		04/14/88	19.50	UNPRINTED	NON
06/29/88	HANNAH DAGWELL		06/29/88	1,137.00	UNPRINTED	NON
12/15/88	ACELA SARTORIUS		12/15/88	1,580.00	UNPRINTED	NON
01/27/89	LISA HOBLIN		01/27/89	108.11	UNPRINTED	NON
03/15/89	THOMAS SHIRLEY		03/15/89	40.00	UNPRINTED*	NON
03/16/89	MARIELY LADD		03/16/89	40.00	UNPRINTED*	NON
03/16/89	DOUG WALLING		03/16/89	3.00	UNPRINTED*	NON
07/14/89	HOWARD RAMEY		07/14/89	3.00	UNPRINTED*	NON
12/01/89	LOUISE BRENNAN		12/01/89	76.40	UNPRINTED*	NON
12/15/89	LOUISE BRENNAN		12/15/89	41.50	UNPRINTED*	NON
12/15/89	DEBORAH RIVENBARK		12/15/89	83.10	UNPRINTED*	NON
02/07/90	LOUISE BRENNAN		02/07/90	107.29	UNPRINTED*	NON
04/19/90	CHARLES CARTER	2607185	04/19/90	121.98	UNPRINTED*	NON
09/13/90	AGNES A. LANGFORD		09/13/90	60.70	UNPRINTED*	NON
10/28/91	JUDY TEMPLER		10/28/91	40.00	UNPRINTED*	NON
11/19/91	KATHY GOYNE		11/19/91	20.00	UNPRINTED	NON
11/19/91	KATHY GOYNE		11/19/91	135.00	UNPRINTED	NON
11/19/91	AGNES A. LANGFORD		11/19/91	389.57	UNPRINTED	NON
11/19/91	GUY RICE		11/19/91	327.00	UNPRINTED*	NON
11/20/91	CLAUDE BOURGAULT		11/20/91	18.00	UNPRINTED	NON
11/20/91	CLAUDE BOURGAULT		11/20/91	40.00	UNPRINTED	NON
11/20/91	C. LLOYD DAWSON		11/20/91	16.00	UNPRINTED	NON
11/20/91	JUDSON EGLIN		11/20/91	16.00	UNPRINTED	NON
11/20/91	JOHN GEROMETTA		11/20/91	64.00	UNPRINTED	NON
11/20/91	JOHN GEROMETTA		11/20/91	77.00	UNPRINTED	NON
11/20/91	JOHN GEROMETTA		11/20/91	16.00	UNPRINTED	NON
11/20/91	LOUISE HOOGENDOORN		11/20/91	171.00	UNPRINTED	NON
11/20/91	KRISTIN ORTON		11/20/91	92.00	UNPRINTED	NON
11/20/91	KRISTIN ORTON		11/20/91	40.00	UNPRINTED	NON
11/20/91	KRISTIN ORTON		11/20/91	16.00	UNPRINTED	NON
11/20/91	JIM TERWILLIGER		11/20/91	16.00	UNPRINTED	NON
11/20/91	MARK WARNER		11/20/91	15.00	UNPRINTED	NON

MDC Summary:

BILLING STATUS	COUNT	AMOUNT
UNPRINTED	35	4,989.65
ON UNPRINTED QUEUE	35	4,989.65
UNBILLED TOTAL:	35	4,989.65

EOB Worksheet

❖

Purpose

To provide a balancing tool prior to posting a carrier's Explanation of Benefits

❖

Features

Indicates how payments were allocated by line item

Keeps EOB as an electronic record

Indicates balances transferred to another carrier or responsible party

❖

Variations

May be compiled for a specific carrier or for all carriers

May be sorted by check date, check number, or posting date

❖

Formats

May be printed in detail or summary

❖

EOB WORKSHEET

John Harrison, M.D.

DETAIL BY CHECK DATE

CARRIER: MDC (MEDICARE)
CHECK#: 1200 ($406.06) POSTED: 01/23/92 by JQP CHECK DATE: 12/27/91

PATIENT	PROCEDURE	DATES	AMOUNT BILLED	AMOUNT ALLOWED	W/O	DEDUCT	CO-INS	80%	100%	PAID	TRANSFER/ WRITE OFF	AMOUNT	BI
Claim Date: 12/01/91													
M ALLISON	90017		50.00	50.00	0.00	0.00	10.00	50.00	0.00	40.00	80%	10.00	
	85021		12.00	12.00	0.00	0.00	2.40	12.00	0.00	9.60	80%	2.40	
Claim Total:			62.00	62.00	0.00	0.00	12.40	62.00	0.00	49.60			
Claim Date: 12/02/91													
C BORGFELDT	90017		50.00	50.00	0.00	50.00	0.00	0.00	0.00	0.00	DED	50.00	
Claim Total:			50.00	50.00	0.00	50.00	0.00	0.00	0.00	0.00			
Claim Date: 12/05/91													
C BOURGAULT	90060		40.00	40.00	0.00	0.00	0.00	40.00	0.00	32.00	WO	8.00C	
Claim Total:			40.00	40.00	0.00	0.00	0.00	40.00	0.00	32.00	WO	8.00C	
Claim Date: 12/10/91													
J BURKE	90017		50.00	50.00	0.00	0.00	10.00	50.00	0.00	40.00	80%	10.00	
	74240		118.57	118.57	0.00	0.00	23.71	118.57	0.00	94.86	80%	23.71	
Claim Total:			168.57	168.57	0.00	0.00	33.71	168.57	0.00	134.86			
Claim Date: 12/11/91													
J BURNETT	90070		50.00	40.00	10.00	0.00	8.00	40.00	0.00	32.00	80%	8.00	
Claim Total:			50.00	40.00	10.00	0.00	8.00	40.00	0.00	32.00	MDC/E		
Claim Date: 12/15/91													
J CALLOWAY	82465		7.00	7.00	0.00	0.00	1.40	7.00	0.00	5.60	80%	1.40	R
	84478		15.00	15.00	0.00	0.00	3.00	15.00	0.00	12.00	80%	3.00	R
	83718		10.00	10.00	0.00	0.00	2.00	10.00	0.00	8.00	80%	2.00	R
	90060		40.00	40.00	0.00	0.00	0.00	40.00	0.00	32.00	80%	0.00	R
											WO	8.00C	
Claim Total:			72.00	72.00	0.00	0.00	6.40	72.00	0.00	57.60	WO	8.00C	
Claim Date: 12/18/91													
C CARTER	90017		50.00	50.00	0.00	0.00	10.00	50.00	0.00	40.00		10.00	R
	90707		40.00	40.00	0.00	0.00	8.00	40.00	0.00	32.00		8.00	R
Claim Total:			90.00	90.00	0.00	0.00	18.00	90.00	0.00	72.00			
Claim Date: 12/20/91													
S GALLAGHER	80060		23.00	23.00	0.00	0.00	4.60	23.00	0.00	18.40		4.60	B
	85021		12.00	12.00	0.00	0.00	2.40	12.00	0.00	9.60		2.40	B
Claim Total:			35.00	35.00	0.00	0.00	7.00	35.00	0.00	28.00			

EOB WORKSHEET

John Harrison, M.D.

DETAIL BY CHECK DATE

ARRIER: MDC (MEDICARE)
HECK#: 1200 ($406.06) POSTED: 01/23/92 by JQP CHECK DATE: 12/27/91

ATIENT	PROCEDURE	DATES	AMOUNT BILLED	AMOUNT ALLOWED	W/O	DEDUCT	CO-INS	80%	100%	PAID	TRANSFER/ WRITE OFF	AMOUNT	BILL
eck Total:			567.57	557.57	10.00	50.00	85.51	507.57	0.00	406.06	WO	16.00C	

OTAL TRANSFERRED (AFTER PAYMENTS) TO R: 120.51
B: 7.00
I: 8.00
OTAL: 135.51

Insurance Payment Report

❖

Purpose

To serve as a tool for evaluating collection ratios by procedure and by insurance carrier

To serve as a practice management tool in the analysis of a carrier's impact on cash flow and revenue

❖

Features

Allows analysis of collection ratio for specific carriers on specific procedures

Assists practice in evaluation of insurance carrier participation

Acts as a reference tool for patient inquiries on an insurance company's average payment for a procedure

Assists practice in fee scheduling

❖

INSURANCE PAYMENT REPORT

John Harrison, M.D.

CARRIER: MDC (MEDICARE)
BEGIN - END

Procedure	Count	Charges	Allowed	%Allowed	Payments	% Received
4240	1	118.57	118.57	100%	94.86	80%
0060	2	53.00	23.00	43%	31.40	59%
1000	1	7.00	0.00	0%	5.05	72%
2465	1	7.00	7.00	100%	5.60	80%
3718	1	10.00	10.00	100%	8.00	80%
4478	1	15.00	15.00	100%	12.00	80%
5021	2	24.00	24.00	100%	19.20	80%
5024	1	12.00	0.00	0%	11.75	98%
0017	4	200.00	200.00	100%	120.00	60%
0060	3	105.50	80.00	76%	64.00	61%
0070	1	50.00	40.00	80%	32.00	64%
0707	1	40.00	40.00	100%	32.00	80%
3000	1	41.60	0.00	0%	0.00	0%
0021TC	1	68.00	0.00	0%	40.16	59%
OTALS:	21	751.67	557.57	74%	476.02	63%

Day Sheet

❖

Purpose

To provide a listing of practice charges, receipts, and adjustments for a specified date or range of dates

To summarize daily financial computer entries

To serve as a reference tool to check billing accuracy

❖

Features

Replaces manual pegboard

Provides total outstanding and month-to-date figures

❖

Variations

May be compiled by physicians, by place of service, or by user

May include month-to-date figures

May be compiled for any user-specified date range

❖

Formats

May be sorted by posting date or by transaction date

❖

DAY SHEET - POSTED 11/15/91

John Harrison, M.D.

ALL USERS

ATIENT/ HART#	PREVIOUS BALANCE	CHARGES	PAYMENTS	ADJUSTMENTS	CURRENT BALANCE
IOS, JULIA	40.00	40.00	80.00	0.00	0.00
NDREWS, MALLORY	256.02	267.00	0.00	0.00	523.02
RNOLD, EDWARD	104.00	35.00	0.00	0.00	139.00
MFORD, ROBERT DC (NO)	0.00	184.00	0.00	0.00	184.00
RLSON, STEPHANIE 9682615	191.00	0.00	20.00	0.00	171.00
ESSER, KAREN	0.00	158.00	0.00	0.00	158.00
MPHER, ARLENE DC (NO)	0.00	16.00	0.00	0.00	16.00
X, MARY FRANCES 9221172 MDC (NO)	52.00	0.00	40.00	0.00	12.00
LLINGER, DOROTHY 802122 MDC (NO)	57.00	89.00	0.00	0.00	146.00
WBERRY, THOMAS 089500	0.00	69.00	0.00	0.00	69.00
RRY, MARGARET CBS (NO)	796.40	40.00	0.00	0.00	836.40
RRY, SHANNON	206.10	40.00	0.00	0.00	246.10
RD, CALVIN	617.00	61.00	0.00	0.00	678.00
RDNER, GERTRUDE 565403	423.00	0.00	100.00	0.00	323.00
EENE, CAROLYN	11.00	11.00	22.00	0.00	0.00
RTT, JOHN RIVATE (NO)	72.00	0.00	57.60	14.40C	0.00
RWICK, ROBERT R. DC (NO)	57.00	99.00	0.00	0.00	156.00
LDERBRAND, BARBARA RIVATE (NO)	228.00	0.00	26.27	0.00	201.73
RDAN, JOSHUA	0.00	79.00	79.00	0.00	0.00
MP, H. THEODORE	0.00	139.00	0.00	0.00	139.00
YER, PATRICIA DC (NO)	0.00	140.00	0.00	0.00	140.00
CKAY, LAUREN RIVATE (NO)	417.80	109.00	0.00	0.00	526.80
HAFFEY, SIDDARTHA DC (NO)	22.00	11.00	0.00	0.00	33.00

DAY SHEET - POSTED 11/15/91

John Harrison, M.D.

ALL USERS

PATIENT/ CHART#	PREVIOUS BALANCE	CHARGES	PAYMENTS	ADJUSTMENTS	CURRENT BALANCE
MILLER, JON 6350790	371.00	40.00	0.00	0.00	411.00
NORTON, JOYCE BCBS (YES)	243.85	119.00	0.00	0.00	362.85
NUHN, ELIZABETH SUE	0.00	61.00	61.00	0.00	0.00
POYER, JOHN	0.00	320.00	320.00	0.00	0.00
ROBINSON, OLENE 312259 MDC (NO)	690.66	22.00	0.00	0.00	712.66
ROBUCK, JOANN	39.00	0.00	39.00	0.00	0.00
ROBUCK, WALTER	53.75	16.00	11.00	0.00	58.75
ROLLYSON, DAN	176.00	0.00	176.00	0.00	0.00
SCHROEDER, WAYNE	0.00	11.00	11.00	0.00	0.00
SKELLY, EDNA MDC (NO)	0.00	139.00	56.00	0.00	83.00
STENCIL, TENA MDC (NO)	36.87	58.00	0.00	0.00	94.87
STEVENS, CURTIS	0.00	114.00	0.00	0.00	114.00
STEWART, JAMES	353.00	0.00	100.00	0.00	253.00
STRATOS, EUGENIA (NI	79.00	73.00	0.00	0.00	152.00
TWOMBLY, DEANE	0.00	117.00	117.00	0.00	0.00
TWOMBLY, ROLAND 5442569	391.00	0.00	391.00	0.00	0.00
VACCA, J. JOSEPH MDC (NO)	125.00	156.00	0.00	0.00	281.00
WAGAMAN, RAY	0.00	40.00	0.00	0.00	40.00
WILLIAMSON, DOROTHY	731.54	0.00	300.00	0.00	431.54
WOMBLE, JOHN	13.80C	163.00	0.00	0.00	149.20
TOTALS:	$6,827.19	$3,036.00	$2,006.87	$14.40C	$7,841.92

DAY SHEET - POSTED 11/15/91

John Harrison, M.D.

ALL USERS

SUMMARY FOR ALL USERS OF 11/15/91 POSTED ACTIVITY

CHARGES:		3,036.00D
INSURANCE PAYMENTS:	0.00	
PATIENT/RP PAYMENTS:	2,006.87C	
		2,006.87C
DEBIT ADJUSTMENTS:	0.00	
CREDIT ADJUSTMENTS:	0.00	
WRITE OFFS:	14.40C	
		14.40C
NET ACTIVITY:		1,014.73D

M-T-D ACTIVITY FOR ALL USERS POSTED AS OF 11/15/91

CHARGES:	34,910.66D
PAYMENTS:	34,539.07C
ORGANIZATION A/R TOTAL AS OF 01/11/92:	130,447.66D

Daily Deposit Slip

❖

Purpose

To use as a worksheet in preparing bank deposits and reconciling bank statements

To streamline deposit process and assure accuracy of bank deposits

❖

Features

Separates cash payments from checks, insurance checks from private checks

❖

Variations

May be compiled for a single day or multiple days

❖

Formats

May be compiled by posting date or by transaction date

May be compiled to include line item detail or in summary by deposit category

❖

DAILY DEPOSIT SLIP

John Harrison, M.D.

OR POSTING DATE: 11/15/91

P/CASH - PAYMENT/CASH:		
RP: PFOHL-COMP,CAROLINE	11.00	
OTAL PP/CASH - PAYMENT/CASH:		$11.00
P/CK - PAYMENT/CHECK:		
RP: BRENNAN,KAREN	22.00	
RP: CAPUTO,DAVID	56.00	
RP: FERRIN,JANE B.	80.00	
RP: GNUSE,JOE	20.00	
RP: GOLDEN,DOROTHY	39.00	
RP: GRIM,RUTH	320.00	
RP: HEFLIN,SHEILA	61.00	
RP: KIRSCH,SHIRLEY	40.00	
RP: LOWE,THOMAS	79.00	
RP: LUNDBERG,JUDSON	100.00	
RP: MAIER,CHARLES	176.00	
RP: ROBUCK,ROBERT	300.00	
RP: SCHEPMOES,JOHN T.	100.00	
RP: TAYLOR,KELLY	11.00	
RP: THOMPSON,ROBERT J.	117.00	
RP: THOMPSON,ROBERT J.	391.00	
OTAL PP/CK - PAYMENT/CHECK:		$1,912.00
NS - INSURANCE PAYMENT:		
RP: FRIEDBERG,KRISTEN	57.60	
RP: YEAKEL,JAMES	26.27	
OTAL INS - INSURANCE PAYMENT:		$83.87
OTAL DEPOSIT:		$2,006.87

DEPOSIT SLIP SUMMARY

John Harrison, M.D.

FOR POSTING DATES: 11/15/91 - 11/15/91

CASH	$11.00
CHECKS	$1,912.00
OTHER (DEPOSITED)	$83.87
TOTAL DEPOSIT	$2,006.87

Unprinted Claims Report

❖

Purpose

To provide a list of unprinted claims for follow up

❖

Features

Provides patient information, visit date, and claim amount

❖

Variations

May be sorted by form number and by carrier

May include primary claims, secondary claims, or both

❖

Formats

May be compiled for any user-specified time period

❖

UNPRINTED CLAIMS REPORT

John Harrison, M.D.

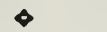
FORM #: 19
CLAIM DATES: BEGIN - END
CLAIM TYPE: PRIMARY/SECONDARY

CARRIER: AETNA (AETNA INSURANCE)

CLAIM DATE	PATIENT	CHART#	VISIT DATE	TOTAL CLA
12/07/90	CATHERINE NYE		12/07/90	0.
12/10/90	CATHERINE NYE		12/10/90	299.
12/13/90	GLENN WOOLDRIDGE		12/13/90	0.
12/20/90	CATHERINE NYE		12/20/90	33.
12/27/90	GLENN WOOLDRIDGE		12/27/90	0.
01/03/91	JULIA SKELLY		01/03/91	0.
01/08/91	JULIA SKELLY		01/08/91	0.
02/21/91	CATHERINE NYE		02/21/91	119.
04/18/91	GLENN WOOLDRIDGE		04/18/91	0.
04/19/91	GLENN WOOLDRIDGE		04/19/91	103.
04/24/91	GLENN WOOLDRIDGE		04/24/91	40.
05/01/91	CATHERINE NYE		05/01/91	294.
05/14/91	CATHERINE NYE		05/14/91	260.
05/23/91	CATHERINE NYE		05/23/91	58.
06/17/91	CATHERINE NYE		06/17/91	267.
06/17/91	ANTHONY WISIACKAS	7609128	06/17/91	0.
07/11/91	ELIZABETH DANIEL		07/11/91	0.
07/19/91	ELIZABETH DANIEL		07/19/91	0.
09/12/91	CATHERINE NYE		09/12/91	40.
11/18/91	ANTHONY WISIACKAS	7609128	11/18/91	0.
		TOTAL:	20 CLAIMS	$1513.

TOTAL FOR ALL CARRIERS: 20 CLAIMS $1513.

Visit Charges by Patient

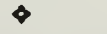


Purpose

To provide detailed visit information by patient

To provide a crosscheck against hospital charge sheets and office superbills

To provide an end-of-year summary of visits for each patient

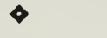


Features

Provides a detailed audit of financial activity

Reports on a patient's activity during a specified time period

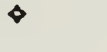
Categorizes patients by billing type



Variations

May be compiled with or without credits and payments

May be compiled with or without zero balance visits



VISIT CHARGES BY PATIENT

CHARGES

John Harrison, M.D.

VISIT/ HOSP STAY DATES	PROCEDURE	DESCRIPTION	AMOUNT
BILLING TYPE: COMPENSATION	04/01/91 - 04/30/91		
KATHERINE COMPHER			
04/10/91	90070	90070 EXTENDED VISIT	55.00
	73030	73030 X-RAY SHOULDER	36.00
	72050	72050 X-RAY CERVICAL SPINE	97.00
	72072	72072 X-RAY DORSAL SPINE	38.00
04/12/91	90060	90060 INTERMEDIATE VISIT	40.00
	97010	97010 HYDROCOLLATOR	19.00
	97128	97128 ULTRASOUND	30.00
04/15/91	90060	90060 INTERMEDIATE VISIT	40.00
	97010	97010 HYDROCOLLATOR	19.00
	97128	97128 ULTRASOUND	30.00
04/16/91	97010	97010 HYDROCOLLATOR	19.00
	97128	97128 ULTRASOUND	30.00
04/17/91	90060	90060 INTERMEDIATE VISIT	40.00
	97010	97010 HYDROCOLLATOR	19.00
	97128	97128 ULTRASOUND	30.00
04/19/91	90060	90060 INTERMEDIATE VISIT	40.00
	97010	97010 HYDROCOLLATOR	19.00
	97128	97128 ULTRASOUND	30.00
04/22/91	90060	90060 INTERMEDIATE VISIT	40.00
04/29/91	90060	90060 INTERMEDIATE VISIT	40.00
		PATIENT TOTAL	711.00
		COMPENSATION TOTAL	711.00

Invoices

Purpose

To serve as a record of patient activity

To serve as a walkout bill

Features

Provides a detailed statement of a visit

Assists patients in filing their own claims

Can be printed and reprinted at any time, in batches or individually

DAVID DEMO, M.D.
3835 Farragut Avenue
Kensington, Maryland 20895
(301) 933-9888

Invoice	DATE	NUMBER
	02/26/90	835

Bill to:

Mrs. Alexander Johnson
234 Main Street
Rockville, MD 20850

Patient:

Mrs. Alexander Johnson
234 Main Street
Rockville, MD 20850

Diagnosis:
795.0 Abnormal Pap

Date	Code	Procedure	Amount
02/26/90	90060	Office Visit - Intermediate	35.00*
02/26/90	86280	Rubella Titer	15.00*
02/26/90	86302	Antibody Screen	30.00*
		Total 02/26/90:	$80.00

* These charges will be submitted to your insurance carrier for payment.

DAVID DEMO, M.D.
10410 North Kensington Parkway
Kensington, Maryland 20895
(301) 933-5800
Fax (301) 588-1111

Invoice	DATE	NUMBER
	02/27/90	53

AMOUNT
REMITTED $ _____

Bill to:

Ms. Janet Goulderman
13467 Old Home Town Road
Cooksville, MD 20824

Patient:

Ms. Janet Goulderman
13467 Old Home Town Road
Cooksville, MD 20824

PLEASE RETURN UPPER PORTION WITH PAYMENT TO INSURE PROPER CRE

Diagnosis:
610.1 Fibrocystic Breast

Date	Procedure	Amount
02/27/90	Intrmdt Office Visit - New	$60.00
02/27/90	Mammogram - Bilateral	85.00
02/27/90	Patient Payment - Cash	50.00CR
	Total 02/27/90:	$95.00

Thank you for your partial payment. Please pay the balance within the next 30 days.

Tax ID # 52-1234567

PLEASE KEEP FOR PERSONAL TAX AND INSURANCE REC

Statements

Purpose

To inform a patient or a designated responsible party of outstanding balances

Features

Allows user-defined dunning messages

Can be printed and reprinted at any time, in batches or individually

Variations

Prints by user-defined batches or by individual responsible party

Formats

ACCLAIM offers over ten statement formats, including one statement per patient or one statement per responsible party

7" or 11" lengths as well as self-mailers are available

DAVID DEMO, M.D.
10410 North Kensington Parkway
Kensington, Maryland 20895
(301) 933-5800
Fax (301) 588-1111

	DATE	NUMBER
Statement	02/28/90	53

AMOUNT
REMITTED $ _____

Bill to:

Ms. Janet Goulderman
13467 Old Home Town Road
Cooksville, MD 20824

Patient:

Ms. Janet Goulderman
13467 Old Home Town Road
Cooksville, MD 20824

PLEASE RETURN UPPER PORTION WITH PAYMENT TO INSURE PROPER CRED

Date	Procedure	Amount
	Previous Balance:	$0.00
02/27/90	Intrmdt Office Visit - New	60.00
	Mammogram - Bilateral	85.00
	Patient Payment - Cash	50.00CR
	Total this statement:	$95.00
	Total Due to Date:	$95.00

All billing inquiries will be accepted between 9:00 a.m. and 3:30 p.m. Monday through Friday.

Tax ID # 52-1234567

PLEASE KEEP FOR PERSONAL TAX AND INSURANCE RECOR

DAVID DEMO

10410 NORTH KENSINGTON PARKWAY
KENSINGTON, MD 20895
(301) 933-5800

Statement

DATE	ACCOUNT NO
03/31/90	58

BALANCE DUE $ 47.70

AMOUNT REMITTED $ _____

Bill to:

Ms. Amy Ledenhall
3654 Parade Terrace
Rockville, MD 20850

Patient:

Ms. Amy Ledenhall
3654 Parade Terrace
Rockville, MD 20850

PLEASE RETURN UPPER PORTION WITH PAYMENT TO INSURE PROPER

DATE	CODE	SERVICES		INSURANCE CLAIM FILED	BILL TO RESPONSIBLE
02/28/90		VISIT DATE-02/05/90			
	90015	Intrmdt Office Visit - New	60.00		
		SENT TO INSURANCE			
	02/28/90	-Insurance has paid us...	35.00C		
		Deductible not met			
	84703	Pregnancy Test	21.00		
		SENT TO INSURANCE			
	02/28/90	-Insurance has paid us...	16.80C		
		Pymt based on 80% coverage			
		DUE FROM YOU			2
03/01/90		VISIT DATE-02/16/90			
	90040	Brief Office Visit - Estbl	35.00		
		SENT TO INSURANCE			
	03/01/90	-Insurance has paid us...	28.00C		
		Pymt based on 80% coverage			
	85031	Complete Blood Count	32.50		
		SENT TO INSURANCE			
	03/01/90	-Insurance has paid us...	26.00C		
		Pymt based on 80% coverage			
	81000	Urinalysis	25.00		
		SENT TO INSURANCE			
	03/01/90	-Insurance has paid us...	20.00C		
		Pymt based on 80% coverage			
		DUE FROM YOU			1
03/07/90	90040	Brief Office Visit - Estbl	35.00		
	80019	Chemistry Profile	40.00		
		SENT TO INSURANCE		75.00	

All billing inquiries will be accepted between 9:00 a.m. and 3:30 p.m. Monday through Friday.

STATEMENT DATE	CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	INSURANCE FILED	BALANCE D
03/31/90	18.50	29.20	0.00	0.00	0.00	75.00	47

Tax ID # 52-1234567

ALTHOUGH WE MAY HAVE FILED AN INSURANCE CLAIM THE TOTAL CHARGES DUE ARE YOUR RESPONSIBILITY

TOTAL CHARGES ARE SUM OF BOTH COL

Claim Forms

Purpose

To inform a patient's designated insurance company of visit charges

Features

Claim forms can be printed and reprinted at any time, in batches or individually

Secondary insurance claim forms can be printed and reprinted at any time, in batches or individually

All information required to have the claim accepted and paid by the insurance company is automatically collected by the system; no need to re-enter information

Claim forms incorporate all current insurance carrier requirements

Variations

Claims can contain multiple visit days, or one claim can be produced for each individual visit

Claims can be consolidated for carriers which allow this flexibility

Formats

ACCLAIM offers over forty claim formats, including the Standard HCFA Claim Form, the latest Medicare Claim Form, several Blue Shield Claim Forms, Medicaid Claim Forms, and the Standard UB82 Hospital Claim Form

AETNA INSURANCE
33060 AETNA BOULEVARD
WASHINGTON DC 20030

HEALTH INSURANCE CLAIM FORM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
NYE, CATHERINE	09 | 22 | 36	NYE, CATHERINE
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 1234 N. STUART STREET PIKE, MD 20852 703-243-2796	5. PATIENT'S SEX MALE [ ] FEMALE [X]	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS) 270000782
	7. PATIENT'S RELATIONSHIP TO INSURED SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE, ENTER NAME OR POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES [ ] NO [ ] B. ACCIDENT AUTO [ ] OTHER [ ]	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 1234 N. STUART STREET PIKE, MD 20852 TELEPHONE NO. 703-243-2796 11a. CHAMPUS SPONSOR'S STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED DATE 09/12/91

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATES	16a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1. 382.9 OTITIS MEDIA, ACUTE
2.
3.
4.

EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO

24. A DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. (FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN) PROCEDURE CODE (CPT/HCPCS)	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. EPSDT FAMILY PLAN	H. LEAVE BLANK
09/12/91		ALL	90060	90060 INTERMEDIATE E 1		40.00	1		

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
X 09/12/91

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [ ] NO [X]

27. TOTAL CHARGE 40.00

28. AMOUNT PAID

29. BALANCE DUE 40

30. YOUR SOCIAL SECURITY NO
90

31. PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS ZIP CODE AND TELEPHONE NO.
John Harrison, M.D.
120 N. Collington Road
Falls Church, VA 22046
Ph 703-386-2974
54-0974153

32. YOUR PATIENT'S ACCOUNT NO

33. YOUR EMPLOYER ID NO
23-9243002

34. PLACE OF SERVICE AND TYPE OF SERVICE CODES ON BACK (REMARKS)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

FORM HCFA-1500 (12-90) FORM OWCP-1500
FORM CHAMPUS 501 (1-91) FORM RRB-1500
AMA CP 503

Established in 1981, Sentient Systems, Inc., is a recognized leader in the areas of high quality software development and systems integration for the medical profession.

Sentient Systems is a sole source provider. The ACCLAIM Medical System offers hardware (IBM or compatible), software, installation, initial data conversion, training, support, and service with every system.

The ACCLAIM Medical System is an expandable, turnkey, microprocessor-based practice management system with the power of a minicomputer. The system can easily manage both solo physician practices and multi-specialty, multi-location practices with many local and remote users.

ACCLAIM's management reports are essential tools for steering a medical practice through today's cost-conscious marketplace. ACCLAIM's User-Defined Reports provide maximum reporting flexibility, allowing your practice to create reports combining any practice data you require. All of ACCLAIM's reports provide flexible report parameters and easy-to-understand formats.

SENTIENT
SYSTEMS

APPENDIX C

Reviewed By: Ja olson
Date: 2/25/92

OBTAINING PRECERTIFICATION ROSTER FROM AQCESS

Purpose: Several health groups and insurance companies require precertification of patients prior to being admitted or within 24 hours of being admitted to a hospital. They require the basic medical information on the patient such as diagnosis, date of admission, surgery procedure planned, etc.

Each morning, after receiving the latest insurance forms from admissions and calling Sandy Slider (Fiscal -6216) concerning those marked YES, print a Precertification Roster.

This report will contain all those individuals, whose insurance companies require precertification information. Patient's name, insurance company, policy number, and phone number will appear on report for ease in determination of precert cases.

NOTIFY MEDICAL RECORDS THAT YOU ARE RUNNING THIS REPORT AND REQUIRE AN APPROXIMATE 5 MIN TO COMPLETE SO THEY CAN ADJUST THEIR WORKLOAD.

Procedure:

1. Enter User Identification number and Password on AQCESS.
2. Under USER AUTHORIZED FUNCTIONS, choose C, CLINICAL RECORD PROCESS.
3. Under CLINICAL RECORDS PROCESSING, choose R: CLINICAL RECORDS REPORT.
4. Print one copy of report. Can obtain hard copy from Room 13.
5. Utilize list to contact insurance companies and health groups.
6. File daily precertification logs and hold for a two month period.

(Rm 13)

FINAL [illegible] — PRIVACY ACT 1974 RUN DATE 22 FEB 1992 0204

PAGE 2

[illegible] ENDING [illegible] HOURS 21 FEB 1992 * 92053 *

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

[illegible] PATIENT NAME / SPONSOR SSN	[illegible]	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME	WARD ES
AAAA [illegible] DISPOSITIONS AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA						
RETURNED TO DUTY						
[illegible]		USS SAMUEL GOMPERS AD 37 / [illegible] CA [illegible]	DIS	NO	1225	ABO / 6W
[illegible]		USS KANSAS CITY / FPO SAN FRANCISCO CA 96670	DIS	NO	1002	ABO / 6W
[illegible]		NAS MOFFETT FIELD / MOFFETT FIELD CA [illegible]035	DIS	NO	1200	ABO / 6N
[illegible]		USS ARKANSAS / [illegible] FRANCISCO CA [illegible]	INJ	NO	1239	ABO / 7W
[illegible]		USS SAMUEL GOMPERS / [illegible]	DIS	NO	1227	ABO / 7W
[illegible]		MCSF [illegible] TAC [illegible] / [illegible] ISLAND CA 9459[illegible]	DIS	NO	1745	ABO / 7W
[illegible]		9[illegible] EMS / CASTLE A F B CA 953[illegible]	DIS	NO	1106	ABO / 9W
[illegible]		[illegible] CO 3/27 INF / FORT ORD CA 93941	DIS	NO	1353	ABO / 9W
[illegible]		HS-[illegible] HCM 15-B / [illegible]AMEDA CA 94501	DIS	NO	1003	ABO / 6W
[illegible]		[illegible] / OAK[illegible] CA 9462[illegible]	DIS	NO	1050	ABO / 6W
[illegible]		MCSF[illegible] / [illegible] ISLAND CA 9459[illegible]	DIS	NO	1045	ABO / 6S
[illegible]		AIMD NAS ALAMEDA / ALAMEDA CA 94501	DIS	NO	2030	ABO / 9N
[illegible]		NAS ALAMEDA PSD / ALAMEDA CA 94501	DIS	NO	1828	ABO / 5S
[illegible]		USS ABRAHAM LINCOLN (CVN-72) / [illegible]	DIS	NO	1100	ABO / 5S
[illegible]		VP 31 / MOFFETT FIELD CA 9[illegible]	DIS	NO	1154	ABO / 9N
[illegible]		VP-31 STUDENT / MOFFETT FIELD CA [illegible]	DIS	NO	0837	ABO / [illegible]

(Find deletion that refers [illegible])

APPENDIX D

APPENDIX E

HOLD AREA

CHECK OFF SHEET

Patient Name _____

SSN _____

REG # _____

Date of Disch: _____

+ 10 days _____

→ [ ] = _____

If the document has not been re-received by this date, immediate action must be taken to locate it.

****

Check the Document(s) this records needs on left hand side:		Check right hand side after report has been placed in record:	If document has not been located within 10 days, list action taken
[ ]	Operation Report Number Reqd: ___	[ ]	_____
[ ]	Narr Sum / Med Bd	[ ]	_____
[ ]	Tissue Report	[ ]	_____
[ ]	Cardiac Cath Report	[ ]	_____
[ ]	Other: Blank Face Sheet	[ ]	_____
[ ]	Other: NS/Med Bd Dictated?	[ ]	_____

****

Initial Analysis by: _____ Date: _____

Final Analysis by: _____ Date to Coding/ Ld Coder init. _____/_____

Comments: _____

APPENDIX F

Reviewed By: GA Olsen
Date: 12/25/92

OBTAINING ER LOG FROM AQCESS

Purpose: Many patients are admitted to the ward directly from the ER. In order to identify these individuals, an ER Daily Log report is available through Aqcess. Utilizing this report will allow the COB to locate a patient in order to gather the necessary insurance information needed to file a claim.

This report needs to be run as a priority each morning. On Mondays, a report should be pulled from Friday thru Sunday to cover weekend periods. **ENSURE YOU NOTIFY MEDICAL RECORDS THAT YOU REQUIRE APPROXIMATE 10 MINUTES TO RUN THIS REPORT SO THEY CAN ADJUST THEIR WORKLOAD!**

Procedure:

1. Enter User Identification number and Password on AQCESS.
2. Under USER AUTHORIZED FUNCTIONS, choose #1, RADT REPORTS.
3. Under RADT REPORT TITLE, choose #14, DAILY ER LOG.
4. Screen will ask for the date (day prior) and the number of copies (1). Hit return.
5. Report will automatically print on printer located in Room 13.
6. Review list for all patients admitted and classified in a retired, dependent, or civilian humanitarian catagory.
7. Contact Admissions or use AQCESS to determine what ward a patient is on.
8. Hand carry an Insurance Pamphlet (Enclosure B) and a DD 2569 (Enclosure S).
9. Have patient fill in required information and proceed with the 3 thru 20 of the original SOP.
10. File all copies of Daily ER Logs and hold for two month period.

APPENDIX G

ADMISSION COVER SHEET
PERSONAL DATA - PRIVACY ACT OF 1974

MTF: NAVHOSP OAKLAND

REGISTER: NAME: EMP/SSN:

A D M I S S I O N

DATE/TIME: SOURCE: DIR CLIN SVC: OTORHINOLARYNGOLOGY (ENT
SEX: AGE: DOB: WARD:

PATIENT CATEGORY: PAY GRADE: ELY STATUS:
MARTIAL STATUS: RACE:
DUTY ZIP: ETHNIC: MAJ COMMAND:
MTF TRANS FROM: RELIGION:
MTF OF INITIAL ADM: INIT ADM DATE:

SPONSOR NAME:

EMERGENCY ADDRESS: PATIENT ADDRESS:
RELATIONSHIP:
NAME:
ADDRESS:

PHONE:

CAUSE OF INJURY: TRAUMA STANAG

ADMITTING PROVIDER:
ADMITTING DX: 1452 CANCER HARD PALATE

DIAGNOSES:

PROCEDURES:

ADMINISTRATIVE REMARKS:

D I S P O S I T I O N

DATE/TIME: _____ TYPE: _____ CON LEAVE: TAKEN _____ REC ___

PRIMARY/ATTENDING PHYSICIAN _____ DATE _____

APPENDIX H

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

62y/o F known metastatic clear cell CA. who underwent SAKrectomy in JAN 89 for recurrence FEB 87 since That Time she has had 1 dose of carboplatin on 13FEB90 c incident (250mg/m2 (440mg)). AT has had few problems since. Weight, Appetite & Energy level are all up.

PMH: (-) MI, CORD, DM HTN

PSH: Varicose veins x3
TAH BSO 87
Trigger finger 90 MEDS
Excision Cystectomy 88 Prednisone
Zantac 150mg BHS
Colace 100mg BID

Allergies PCN/C

PHYSICAL EXAMINATION

Gen: Pleasant WA WN 62y/o F. A&O x3

HEENT: NC/AT EXG: EOMI, PERRLA

Lungs - clear

Heart - RRR; S1S2 ± M E

Abd: Well healed U-scar subcostal & suburbilical midline scar

? suture, L merg in U-scar NT ND B.S.(+), ØMASSES

Ext - C
Cyt -
Clubb -

LABS 138 | 103 | 14 / 151
4.3 | 21.6 / 0.6

5.2 / 12.7 / 35.3 / 91

PROGRESS (Enter date of discharge and final diagnosis)

will Admit For carboplatin ↑ DOSE to 540mg & Xanax, Reglan, Decadron, Compazine & Benadryl

SIGNATURE OF PHYSICIAN	DATE	ID	ORGANIZATION

PATIENT IDENTIFICATION (Forstyped for Miller Hospital Name last, first, middle, maid, date, hospital or medical facility)	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.304-4
OCTOBER 1973 135-105

APPENDIX I

OPERATION REPORT

PREOP DG: MULTIFOCAL DUCTAL IN SITU CARCINOMA OF THE LEFT BREAST

SURGEON:

FIRST ASSISTANT:

SECOND ASSISTANT:

SUPERVISORY ASSISTANT:

ANESTHETIST:

ANESTHETIC: GENERAL WITH FORANE

START: 0855 END: RECOVERY ROOM

SURG NURSE: INSTR NURSE:

OPERATION START: 0955 COMPLETED: 1214

OPER DG: MULTIFOCAL DUCTAL IN SITU CARCINOMA, LEFT BREAST

DRAINS: TWO 10 MM JACKSON-PRATT DRAINS PLACED

SPONGE/NEEDLE: CORRECTLY VERIFIED BY LCDR GABRIELSON

LAB SPEC: LEFT BREAST TISSUE, SUPERIOR MARGIN MARKED BY SUTURE

SURGICAL PROCEDURE: LEFT SIMPLE MASTECTOMY

DATE: 08 MARCH 1990

INDICATIONS: The patient is a sixty-four year old with a previous right modified radical mastectomy. She was noted to have ductal carcinoma in situ by needle localized breast biopsy.

FINDINGS:

DESCRIPTION: The patient was taken to the operating room and prepped and draped in the sterile manner. An ellipse was made on the skin at the medial border just lateral to the sternum. The lateral border was at approximately the level of the edge of the latissimus dorsi muscle. The ellipse was made in a 3-1 manner. The skin was carefully incised with the knife. The subcutaneous fat and fascia was then excised with the

SSN: D: T:
NAME:
STATUS: PHYSICIAN ID:
REG.NO: WARD: DOC. ID:
Document Name:

APPENDIX J

SUMMARY OF PERCENTAGES COLLECTED BY SAMPLED HOSPITALS (FY 1988)

HOSPITAL * OR LOCATION	TOTAL INPATIENTS	TOTAL PROGRAM CLAIMS	TOTAL PROGRAM COLLECTIONS	TOTAL AMOUNT CLAIMED	AMOUNT CLAIMED FOR COLLECTIONS	AMOUNT COLLECTED	PERCENTAGE COLLECTED
ARMY							
Eisenhower AMC	10,198	1,076	949	$ 2,408,390	$2,151,333	$1,732,442	80.53
Tripler AMC	16,565	420	224	1,068,666	554,495	439,925	79.34
Madigan AMC	17,256	336	212	660,883	406,307	343,326	84.50
Fitzsimons AMC	11,514	241	132	692,315	392,019	323,261	82.46
Walter Reed AMC	18,093	151	81	431,128	240,999	213,584	88.62
Letterman AMC	9,249	71	10	238,038	18,640	6,808	36.52
Wm. Beaumont AMC	16,665	42	14	140,218	58,716	46,798	79.70
Brooke AMC	15,931	0	0	0	0	0	.00
NAVY							
Oakland	8,853	258	203	433,176	307,488	274,644	89.32
Portsmouth	12,532	190	120	431,348	277,127	247,273	89.23
Camp Pendleton	4,592	58	40	118,189	89,372	73,100	81.79
San Diego	13,034	200	110	477,111	241,806	201,620	83.38
Jacksonville	5,984	95	33	166,532	46,600	34,599	74.25
Newport	736	17	4	47,066	7,456	7,081	94.97
Great Lakes	1,992	10	9	9,786	7,922	6,833	86.25
Bethesda	9,745	46	7	220,007	24,698	17,342	70.22
AIR FORCE							
Tinker AFB	2,455	90	75	159,932	145,486	117,629	80.85
Lackland AFB	18,551	605	357	2,700,605	1,635,503	1,161,005	70.99
Williams AFB	1,028	45	19	51,538	22,382	10,634	47.51
Travis AFB	7,453	238	121	758,100	313,148	263,406	84.12
Homestead AFB	2,811	42	27	85,279	58,251	48,827	83.82
Edwards AFB	1,094	12	8	20,812	15,220	12,183	80.05
Mather AFB	3,459	63	14	122,558	18,640	13,362	71.68
Fairchild AFB	2,408	7	1	7,837	916	438	47.82
Pease AFB	1,720	0	0	0	0	0	.00
TOTAL	213,918	4,313	2,770	$11,449,514	$7,034,524	$5,596,120	79.55

* Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

APPENDIX K

SUMMARY OF PERCENTAGES COLLECTED BY SAMPLED HOSPITALS (FIRST QUARTER FY 1989)

HOSPITAL * OR LOCATION	TOTAL INPATIENTS	TOTAL PROGRAM CLAIMS	TOTAL PROGRAM COLLECTIONS	TOTAL AMOUNT CLAIMED	AMOUNT CLAIMED FOR COLLECTIONS	AMOUNT COLLECTED	PERCENTAGE COLLECTED
ARMY							
Eisenhower AMC	2,549	285	249	$ 671,914	$ 570,220	$ 428,267	75.11
Tripler AMC	4,141	63	23	187,894	91,166	67,659	74.22
Madigan AMC	4,314	62	43	170,402	99,760	92,488	92.71
Fitzsimons AMC	2,878	100	53	378,731	189,646	167,434	88.29
Walter Reed AMC	4,523	14	8	27,552	20,664	17,171	83.10
Letterman AMC	2,312	15	2	39,656	4,194	2,728	65.05
Wm. Beaumont AMC	4,166	9	4	19,760	6,916	6,333	91.57
Brooke AMC	3,983	30	4	60,762	6,916	5,773	83.47
NAVY							
Oakland	2,213	77	58	175,243	136,647	115,725	84.69
Portsmouth	3,133	3	1	6,058	3,262	3,162	96.93
Camp Pendleton	1,148	14	13	27,170	24,700	20,434	82.73
San Diego	3,259	35	9	58,622	14,740	12,139	82.35
Jacksonville	1,496	8	3	14,018	5,704	5,479	96.06
Newport	184	8	1	7,904	988	988	100.00
Great Lakes	498	0	0	0	0	0	.00
Bethesda	2,436	8	2	25,752	8,854	8,192	92.52
AIR FORCE							
Tinker AFB	614	29	17	56,850	27,664	20,083	72.60
Lackland AFB	4,638	93	56	483,128	205,444	162,841	79.26
Williams AFB	257	14	7	16,302	9,880	7,020	71.05
Travis AFB	1,863	32	9	90,206	22,724	20,995	92.39
Homestead AFB	703	2	2	6,916	6,916	6,181	89.37
Edwards AFB	274	15	10	31,122	24,206	22,759	94.02
Mather AFB	865	3	1	5,928	2,964	2,727	92.00
Fairchild AFB	602	1	1	972	972	300	30.86
Pease AFB	430	0	0	0	0	0	.00
TOTAL	53,479	920	576	$2,562,862	$1,485,147	$1,196,878	80.59

* Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

APPENDIX L

PROJECTED PROGRAM COLLECTIONS, ARMY THIRD PARTY COLLECTION PROGRAM (FY 1988)

ARMY * HOSPITALS	TOTAL INPATIENTS	INSURANCE COVERAGE (PERCENTAGE)	PROJECTED INPATIENTS' INSURANCE COVERAGE	INSURANCE BILLING RATE	AVERAGE BED DAYS	COLLECTIONS AT 100 PERCENT	PROJECTED COLLECTIONS AT 80 PERCENT
Walter Reed AMC, DC	18,093	7.69	1,391	$466	8.13	$ 5,271,247	$ 4,216,998
Madigan AMC, WA	17,256	7.69	1,327	466	4.63	2,863,079	2,290,463
Wm. Beaumont AMC, TX	16,665	7.69	1,282	466	4.40	2,627,667	2,102,133
Tripler AMC, HI	16,565	7.69	1,274	466	4.62	2,742,494	2,193,995
Brooke AMC, TX	15,931	7.69	1,225	466	6.91	3,944,876	3,155,901
Fitzsimons AMC, CO	11,514	7.69	885	466	7.44	3,069,809	2,455,848
Fort Bragg, NC	11,029	7.69	848	466	3.80	1,501,869	1,201,495
Fort Hood, TX	10,882	7.69	837	466	3.27	1,275,172	1,020,138
Eisenhower AMC, GA	10,198	7.69	784	466	5.50	2,009,972	1,607,977
Letterman AMC, CA	9,249	7.69	711	466	6.90	2,286,947	1,829,558
Fort Ord, CA	7,490	7.69	576	466	3.60	966,266	773,013
Fort Benning, GA	7,188	7.69	553	466	3.77	971,095	776,876
Fort Campbell, KY	6,665	7.69	513	466	3.38	807,289	645,831
Fort Belvoir, VA	6,174	7.69	475	466	3.20	707,993	566,394
Fort Sill, OK	6,039	7.69	464	466	3.78	818,030	654,424
Fort Carson, CO	5,407	7.69	416	466	3.62	701,418	561,135
Fort Knox, KY	5,252	7.69	404	466	3.90	734,009	587,207
Fort Riley, KS	5,093	7.69	392	466	3.50	638,784	511,027
Fort Polk, LA	4,974	7.69	383	466	3.13	557,908	446,326
Fort Leonard Wood, MO	4,372	7.69	336	466	3.52	551,487	441,189
Fort Stewart, GA	4,244	7.69	326	466	3.34	507,965	406,372
Fort Jackson, SC	3,675	7.69	283	466	5.34	703,252	562,601
Fort Rucker, AL	2,860	7.69	220	466	3.38	346,414	277,131
Fort Huachuca, AZ	2,668	7.69	205	466	3.60	344,192	275,353
Fort Wainwright, AK	2,277	7.69	175	466	2.90	236,632	189,306
Fort Eustis, VA	2,191	7.69	168	466	3.64	285,796	228,637
Fort McClellan, AL	1,992	7.69	153	466	3.75	267,690	214,152
Fort Meade, MD	1,976	7.69	152	466	2.52	178,443	142,754
Fort Leavenworth, KS	1,912	7.69	147	466	3.12	213,774	171,019
Fort Dix, NJ	1,703	7.69	131	466	3.91	238,618	190,895
West Point, NY	1,691	7.69	130	466	3.54	214,516	171,613
Fort Lee, VA	1,374	7.69	106	466	4.32	212,707	170,166
Redstone Arsenal, AL	1,206	7.69	93	466	4.12	178,056	142,445
Fort Devens, MA	1,052	7.69	81	466	4.07	153,434	122,747
Fort Irwin, CA	880	7.69	68	466	2.29	72,215	57,772
Fort Monmouth, NJ	827	7.69	64	466	3.87	114,691	91,753
Fort Harrison, IN	320	7.69	25	466	2.56	29,356	23,485
TOTAL	228,884		17,601			$39,345,163	$31,476,130

* Army Medical Centers (AMC's) are listed by name; other Army hospitals are listed by location.

APPENDIX M

PROJECTED PROGRAM COLLECTIONS, NAVY THIRD PARTY COLLECTION PROGRAM (FY 1988)

NAVAL HOSPITALS *	TOTAL INPATIENTS	INSURANCE COVERAGE (PERCENTAGE)	PROJECTED INPATIENTS' INSURANCE COVERAGE	INSURANCE BILLING RATE	AVERAGE BED DAYS	COLLECTIONS AT 100 PERCENT	PROJECTED COLLECTIONS AT 80 PERCENT
San Diego, CA	13,034	7.69	1,002	$466	5.0	$ 2,312,039	$ 1,849,631
Portsmouth, VA	12,532	7.69	964	466	4.5	2,016,411	1,613,129
Bethesda, MD	9,745	7.69	749	466	6.5	2,283,872	1,827,098
Oakland, CA	8,853	7.69	681	466	4.4	1,402,249	1,121,799
Jacksonville, FL	5,984	7.69	460	466	3.6	763,403	610,722
Charleston, SC	5,695	7.69	438	466	3.7	761,228	608,982
Camp Pendleton, CA	4,592	7.69	353	466	5.3	863,920	691,136
Camp Lejeune, NC	3,388	7.69	261	466	3.4	415,223	332,179
Pensacola, FL	3,211	7.69	247	466	2.9	329,093	263,274
Bremerton, WA	3,143	7.69	242	466	3.9	433,628	346,902
Orlando, FL	2,484	7.69	191	466	3.8	336,477	269,182
Cherry Point, NC	2,466	7.69	190	466	2.6	231,530	185,224
Great Lakes, IL	1,992	7.69	153	466	3.5	246,989	197,591
Millington, TN	1,979	7.69	152	466	3.0	209,209	167,367
Twentynine Palms, CA	1,646	7.69	127	466	2.5	147,463	117,970
Beaufort, SC	1,509	7.69	116	466	3.4	185,479	148,383
Lemoore, CA	1,417	7.69	109	466	2.9	146,243	116,994
Oak Harbor, WA	1,405	7.69	108	466	2.4	118,823	95,058
Groton, CT	1,249	7.69	96	466	3.1	136,961	109,569
Corpus Christi, TX	974	7.69	75	466	3.7	127,398	101,919
Patuxent River, MD	738	7.69	57	466	2.7	70,348	56,278
Newport, RI	736	7.69	57	466	3.5	92,048	73,639
Philadelphia, PA	618	7.69	48	466	3.0	67,103	53,683
Long Beach, CA	530	7.69	41	466	4.7	88,696	70,957
Adak, AK	337	7.69	26	466	2.7	32,124	25,699
TOTAL	90,257		6,941			$13,817,957	$11,054,365

* Naval hospitals are listed by name and location.

APPENDIX N

PROJECTED PROGRAM COLLECTIONS, AIR FORCE THIRD PARTY COLLECTION PROGRAM (FY 1988)

AIR FORCE HOSPITALS*	TOTAL INPATIENTS	INSURANCE COVERAGE (PERCENTAGE)	PROJECTED INPATIENTS' INSURANCE COVERAGE	INSURANCE BILLING RATE	AVERAGE BED DAYS	COLLECTIONS AT 100 PERCENT	PROJECTED COLLECTIONS AT 80 PERCENT
Lackland AFB, TX	18,551	7.69	1,427	$466	9.0	$ 5,983,043	$ 4,786,434
Kessler AFB, MS	9,070	7.69	697	466	7.1	2,307,692	1,846,154
Andrews AFB, MD	7,517	7.69	578	466	6.0	1,616,248	1,292,999
Travis AFB, CA	7,453	7.69	573	466	6.4	1,709,320	1,367,456
Eglin AFB, FL	6,692	7.69	515	466	3.9	935,261	748,209
Wright-Patterson AFB, OH	6,526	7.69	502	466	5.7	1,333,012	1,066,410
Scott AFB, IL	6,157	7.69	473	466	6.1	1,345,895	1,076,716
Carswell AFB, TX	5,029	7.69	387	466	4.8	865,038	692,030
Langley AFB, VA	4,468	7.69	344	466	3.9	624,439	499,551
Offutt AFB, NE	4,152	7.69	319	466	3.7	550,518	440,414
MacDill AFB, FL	3,986	7.69	307	466	3.8	542,792	434,233
Elmendorf, AK	3,915	7.69	301	466	4.5	631,330	505,064
Mather AFB, CA	3,459	7.69	266	466	4.2	520,610	416,488
March AFB, CA	3,211	7.69	247	466	4.9	563,831	451,064
USAF Academy, CO	3,103	7.69	239	466	4.0	444,789	355,831
Luke AFB, AZ	2,914	7.69	224	466	3.9	407,255	325,804
Homestead AFB, FL	2,811	7.69	216	466	4.0	402,933	322,347
Maxwell AFB, AL	2,704	7.69	208	466	4.8	465,115	372,092
Ellsworth AFB, SD	2,687	7.69	207	466	2.6	250,353	200,283
Davis-Monthan AFB, AZ	2,660	7.69	205	466	3.8	362,224	289,779
Dyess AFB, TX	2,627	7.69	202	466	3.1	291,833	233,466
Barksdale AFB, LA	2,626	7.69	202	466	4.2	395,236	316,189
Sheppard AFB, TX	2,622	7.69	202	466	4.8	451,010	360,808
Tinker AFB, OK	2,455	7.69	189	466	3.3	290,320	232,256
Fairchild AFB, WA	2,408	7.69	185	466	3.2	276,133	220,907
Hill AFB, UT	2,096	7.69	161	466	3.3	247,866	198,293
Nellis AFB, NV	2,079	7.69	160	466	3.3	245,856	196,685
Shaw AFB, SC	1,964	7.69	151	466	3.8	267,447	213,957
Kirtland AFB, NM	1,827	7.69	140	466	3.6	235,697	188,557
F. E. Warren AFB, WY	1,800	7.69	138	466	2.9	187,061	149,649
Castle AFB, CA	1,755	7.69	135	466	3.4	213,830	171,064
Minot AFB, ND	1,726	7.69	133	466	3.5	216,482	173,185
Pease AFB, NH	1,720	7.69	132	466	4.1	252,711	202,169
Tyndall AFB, FL	1,643	7.69	126	466	4.0	235,510	188,408
Dover AFB, DE	1,576	7.69	121	466	3.2	180,725	144,580
Robins AFB, GA	1,505	7.69	116	466	4.1	221,122	176,898
George AFB, CA	1,473	7.69	113	466	3.1	163,635	130,908
Mountain Home AFB, ID	1,433	7.69	110	466	3.1	159,192	127,353
Cannon AFB, NM	1,398	7.69	108	466	3.9	195,382	156,305
Moody AFB, GA	1,381	7.69	106	466	3.5	173,210	138,568
Grand Forks AFB, ND	1,378	7.69	106	466	2.8	138,267	110,614
Seymour Johnson AFB, NC	1,364	7.69	105	466	3.2	156,414	125,131

(Air Force hospitals continued on page 52.)

APPENDIX O

NARRATIVE SUMMARY

ADM DATE: 08/08/89 DISCH DATE: 09/15/89

ADMISSION DIAGNOSIS: LUMBAR SPINE INSTABILITY.

HISTORY OF PRESENT ILLNESS: Patient is a 78-year-old white male with a history of cauda equina syndrome in 1985, who presents with a chief complaint of left foot drop for two to three months. Patient has noted increased left lower extremity weakness and difficulty with ambulation. Currently, the patient requires a four-point walker for ambulation. Patient has noted the progressive onset of left lower extremity weakness and decreased sensation in his lower extremities, after left total knee arthroplasty in 1986. Patient has had urinary incontinence since February, 1985, when he underwent decompressive laminectomies of L3 through L5 for cauda equina syndrome.

PAST HISTORY: Except as noted above, the patient's past history, family history, and social history are noncontributory to the present illness.

PHYSICAL EXAMINATION: Patient is a well-developed white male in no acute distress. HEENT within normal limits. Lungs were clear to auscultation. Heart rhythm and rate were regular, with occasional extra beats, without murmurs, gallops, or rubs. Abdomen: Soft. Without tenderness. Rectal: Decreased tone. Normal sensation. Enlarged prostate, without nodules. Heme-negative. Lower extremities: Deep tendon reflexes were 0/4 bilaterally, with downgoing toes. Muscle strength was 5/5 bilaterally, except for the left gastrosoleus which was 3/5, left tibialis anterior 0/5, left extensor hallucis longus 0/5, and left peroneals 0/5. Sensation was noted to be decreased bilaterally in a stocking-glove distribution.

LABORATORY STUDIES: CBC, PT, PTT, and chemistries were within normal limits.

X ray of the lumbosacral spine revealed Grade I spondylolisthesis of L5 upon S1 and L4 upon L5 and retrospondylolisthesis of L3 upon L4 and L2 upon L3. Degenerative joint disease. Absent lamina L3 through L5.

SSN: D: T:
NAME:
STATUS: PHYSICIAN ID:
REG.NO: WARD: DOC. II

APPENDIX P

RECORD OF INPATIENT TREATMENT
PERSONAL DATA - PRIVACY ACT OF 1974

REGISTER: [illegible] NAME: [illegible] FMP/SSN: [illegible]

ADMISSION

[illegible] SOURCE: DIR CLIN SVC: CARDIOLOGY
SEX: M AGE: 70Y DOB: [illegible]

DISPOSITION

[illegible] TYPE: DCIV CLIN SVC: CARDIOLOGY

DIAGNOSES

1. Principal DX: 4111- -U
INTERMEDIATE CORONARY SYNDROME
(UNSTABLE ANGINA)

2. 4139- -U
OTHER AND UNSPECIFIED ANGINA PECTORIS
(SEVERE CHRONIC ANGINA)

3. 4241- -U
CORONARY ATHEROSCLEROSIS

4. 412- -U
OLD MYOCARDIAL INFARCTION
(HISTORY OF ANTERIOR WALL MYOCARDIAL INFARCTION IN JULY 1991)

5. 7821- -U
NONSPECIFIC ABNORMAL FINDINGS IN STOOL CONTENTS
(GUAIC POSITIVE STOOL)

6. V1052- -U
PERSONAL HISTORY OF MALIGNANT NEOPLASM OF KIDNEY
(HISTORY OF RENAL CELL CARCINOMA)

7. V1011- -U
PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BRONCHUS AND LUNG
(HISTORY OF BRONCHOGENIC CARCINOMA)

8. 2886- -U
OTHER SPECIFIED DISEASE OF WHITE BLOOD CELLS
(MILD PLASMACYTOSIS (1%))

PROCEDURES

1. Principal PX: 3700-2-1 SIGNED: HILL,DAVID M
LEFT HEART CARDIAC CATHETERIZATION

2. 3950 1-1 SIGNED: HILL,DAVID M
PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY OF LEFT HEART STRUCTURE

[illegible]

[illegible] FMP/SSN: [illegible]

[illegible]

APPENDIX Q

MEDICAL RECORD | **DOCTOR'S ORDERS**
Sign all orders

DATE AND TIME		RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP				

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO | WARD NO.

*U.S. Government Printing Office: 1990 — 281-782/20299

DOCTOR'S ORDERS

APPENDIX R

BEFORE AND DURING ADMISSION

1- At what point in the admission process is the patient first questioned about health insurance?

2- Is the patient health insurance plan verified?

3- When is the verification done?

4- Who does the verification?

5- Is the verification done by phone or by computer?

6- During verification do you also have to get approval for the given care?

7- How many personnel are involved in the verification phase?

8- Are the personnel assigned on a permanently or temporally basis?

9- If temporally assigned for how long?

10- Are personnel require before assignment to undergo training?

11- How long is the training?

12- Where do they go to get this training?

13- Are refresher training given and how often?

14- What is the cost of training per employee?

15- Who is responsible for the training program?

16- What are some of the major obstacles that may delay payments from the insurance companies?

17- What is the time and cost spent on correcting errors?

ONCE THE PATIENT IS ADMITTED

18- How is billing information collected?

19- What forms are used? and who is responsible for preparing these forms?

20- Who is responsible for coding the patient information?

21- Is the coding done manually or with computers?

22- When is the patient billing information send to the billing department?

23- Are the patient billing updated on a daily basis?

24- Who is responsible for keeping this information up-to-date?

25- Is that his/her primary duty? or is it shared by more than one person?

26- What skills, training or level of proficiency are necessary to perform these duties?

27- Do you have ongoing training? Is it inhouse or outside?

28- Who coordinates the training?

29- What is your annual cost of training personnel assigned to these duties?

30- What is the per patient cost of information collection and summary?

BILLING AND COLLECTION

31- At what point is the insurance company billed?

32- How soon after the patient is discharged is the bill forwarded to the insurance company?

33- What is the average A/R turnover for health insurance billing?

34- What is the hospital payment terms? (i.e. 30,60, 90 days)

35- What percentage of the claims are unpaid or partially unpaid for inappropriate reasons?

36- What percentage of claims require follow up billing?

37- How are follow ups conducted? (mail, phone, computer, etc)

38- Do you utilized the service of an outside collection agency?

39- What criteria do you used to select that collection agency?

40- What is the cost or the rate charged by the collection agency?

41- Have you ever changed collection agency? why?

42- When is the A/R refer to a collection agency?

43- What percentage of patient billings are referred to a collection agency?

44- What percentage of A/R are uncollectible? (bad debt)

45- Have you considered contracting out the billing and collection (ie. using Clearing House, TRW, etc.)? Why? or Why not?

46- Are there instances where the amount billed has been adjusted downward because not getting pre-authorization from the insurance company?

47- Have you heard about Electronic Claim?

48- Will you considered using it in this hospital setting? Why or Why not?

49- What computer software is used for billing and collection? (i.e. inhouse developed system, commercial software)

50- What was the cost? What maintenance is needed?

THIRD PARTY COLLECTION PROGRAM
INSURANCE INFORMATION

PRIVACY ACT STATEMENT

AUTHORITY: Title USC, Sec 1095 and EO 9397

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for inpatient care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility.

ROUTINE USE(S): The information on this form will be released only to your insurance company.

DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

SECTION I – PATIENT INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SSN OF SPONSOR	3. DATE OF BIRTH *(YYMMDD)*
4. REGISTER NUMBER *(Hospital Use Only)*	5. MARITAL STATUS	6. RELATION TO INSURED
7. ADDRESS *(Street, City, State and Zip Code)*	8. TELEPHONE NUMBER *(include Area Code)*	
	a. HOME	b. OFFICE
	9. ADMISSION	10. ACCIDENT
	a. DATE *(YYMMDD)* b. HOUR	a. DATE *(YYMMDD)* b. HOUR
11. DO YOU HAVE HEALTH INSURANCE? *(X one)* ☐ YES ☐ NO *If Yes, complete Section II. If No, go to Section III.*	12. IF YES, IS THIS A SUPPLEMENT TO: *(X as applicable)* ☐ CHAMPUS ☐ MEDICARE/MEDICAID	

SECTION II – INSURANCE CARRIER INFORMATION

13. NAME OF INSURED *(Last, First, Middle Initial)*			14. SSN
15. POLICY NUMBER		16. EFFECTIVE DATE *(YYMMDD)*	17. RENEWAL DATE *(YYMMDD)*
a. INDIVIDUAL	b. GROUP		
18. IS THIS THE PRIMARY POLICY FOR INSURANCE PURPOSES? *(X one)* ☐ YES ☐ NO			
19. INDIVIDUAL INSURANCE COMPANY NAME		20. INSURANCE COMPANY ADDRESS *(Street, City, State and Zip Code)*	
21. TELEPHONE NUMBER *(include Area Code)* Extension			
22. INSURED EMPLOYER NAME		23. EMPLOYER ADDRESS *(Street, City, State and Zip Code)*	
24. TELEPHONE NUMBER *(include Area Code)* Extension			
25. NAME OF GROUP INSURANCE PLAN *(if applicable)*			26. GROUP PLAN NUMBER

SECTION III – CERTIFICATIONS

27. PATIENT

I certify that the above information is true and accurate to the best of my knowledge. I hereby authorize and request that the proceeds of any and all benefits which may be due under the attached claim(s) be paid directly to the facility of the uniformed service or other authorized representative of the United States for hospitalization and professional services provided me or my dependents.

a. SIGNATURE	b. DATE SIGNED *(YYMMDD)*

29. THIRD PARTY LIABILITY CLERK

This admission has been identified as a Third Party Liability Case under PL 87-693 *(X one)* ☐ YES ☐ NO

a. SIGNATURE	b. DATE SIGNED *(YYMMDD)*

APPENDIX T

NAVHOSP Oakland
Naval Hospital Oakland
OAKLAND, CA 94627

0163192

111

HARRIS,KATHLEEN R

ALL INCL HOSPITAL CHARGES	423.00	101	6	2538.00
ALL INCL ANCIL	238.00	240	6	1428.00
PRO FEE	35.00	960	6	210.00

TOTAL CHARGES: 4206.00

AETNA HEALTH INSURANCE — 0.00 — 4206.00

DUE FROM PATIENT

INSURED'S NAME	REL	INSURED'S SSN/HIC ID NO	GROUP NAME	INSURANCE GROUP NO
HARRIS,KATHLEEN R	01	271-76-7394	AGIF INVENTORY	600540031
		535484-10-000		

A 19

PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS

ENLARGEMENT OF LYMPH NODES — 7856 — 7866

PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS

9 BIOPSY OF BONE MARROW — 4131 04-15 — 8801 04-14

ATTENDING PHYSICIAN ID: BOWER.DOUGLAS J.

PAYER COPY

UB-82 HCFA 1450

LIST OF REFERENCES

1. DoD INSTRUCTION 6010.15, "Third Party Collection (TPC) Program," March 7, 1991.

2. BUMED INSTRUCTION 7000.7, "Third Party Collection Program," Draft BUMED-13.

3. DoD Office of the Inspector General, Audit Report on "Third Party Collection Program," dated August 30, 1990. Report No. 90-105.

4. Community Hospital of the Monterey Peninsula (CHOMP), "History of Community Hospital,"Information and Service Office, Monterey, California 93942.

5. Naval Hospital Oakland (NHO), "Background and History," Public Affairs Office, Oakland, California.

6. Naval Hospital Oakland, "Third Party Collection Program Standard Operating Procedures," Oakland, California.

7. Naval Hospital Oakland, "Third Party Collection Program Review," by CDR Lynn C. Griswold, dated May 17, 1991.

8. Interview with Mrs. Sandra Slider, Fiscal Department, Naval Hospital Oakland, Oakland, California, July 23 and 24, 1992.

9. Interview with Mr. W. Bishop, Vice President for Finance, Community Hospital of the Monterey Peninsula, Monterey, California, July 14, 1992.

10. Automated Quality of Care Evaluation Support System (AQCESS), "Third Party Collections Resource Handbook," August 19, 1991.

11. DoD 7220.9-M, "DoD Accounting Manual," February 1988 as authorized by DoD Instruction 7220.9 of October 22, 1981.

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